MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building
International Trade Center
Horizon Ballroom
1300 13th Street, N.W.
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Thursday, April 12, 2001
10:27 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
BEA BRAUN, M.D.
AUTRY O.V. DeBUSK
GLENN M. HACKBARTH
FLOYD D. LOOP, M.D.
ALAN R. NELSON, M.D.
JANET G. NEWPORT
CAROL RAPHAEL
ROBERT D. REISCHAUER, Ph.D.
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.

AGENDA PAGE

AFTERNOON SESSION [1:52 p.m.]

DR. WILENSKY: Let's reconvene. I want to begin by turning it over to Glenn to share with us the results of the caucusing done with David and I think Bob Reischauer was involved with this, and a little advice from HCFA to make sure we had an understanding about the current scope of work by the PROs. Glenn?

MR. HACKBARTH: I failed, Gail, to come up with language that mustered more support, more enthusiastic support, than what we had already voted on. I think we probably have gone past the point of diminishing returns in the discussion.

So with that in mind, I recommend that we just stand by the vote that we've already taken and move on.

DR. WILENSKY: I think maybe what we can try to do is raise in discussions, in the discussion that follows the recommendation, some of the issues that we talked about. If it wasn't clear, you can make sure, sharing with Murray, the sense of what we want to make sure is included in that paragraph following the recommendation.

Let me turn this over to Jack.

MR. ASHBY: A couple of introductory remarks here. First of all, you'll be happy to know that we really tried to limit our presentation here today. It's still not exactly what one would call short, but we really did work at limiting it down.

We are only going to present the draft recommendations --

DR. NEWHOUSE: We need a quality assurance methods to shorten a presentation.

MR. ASHBY: Better than ever, that's right. We hope.

We're only going to present the draft recommendations themselves, or options for recommendations if that's as far as our thinking has gone. And in a few cases, analyses that are new since our last meeting. Most of those new analyses are estimates of the impact of these various policy options. I'm sure you all noticed that they were not in your mailing materials. They just came off the computer about last night, as a matter of fact.

We have a couple of other scattered things that don't exactly fit into the flow of the presentation, but are new and we thought that you'd find them interesting and so we kind of inserted them briefly into the presentation.

If you look at the first overhead, this is an outline of where we're going here. We'll start out by returning to the financial analysis that Jesse presented last time. Here we have only one chart to present, so that's a one minute session. Then we're going to work our way through the five areas where we do have potential recommendations.

Now the chapter has one additional session, and that's the treatment of length of stay. But I just wanted to remind ourselves that we decided last time that we're going to hold that until the next cycle. So we left it off the agenda today all together.

Lastly is an entirely separate discussion of payment issues that have to do with rural site facilities, that Sally will be doing.

If you look at the next overhead, I wanted to

explain our impact analysis briefly.

DR. ROWE: Before you get started, Jack, can I ask the chairs how we're going to do this? Are we going to do this sort of when we get to the recommendation -- could we have a lot of different pieces, as Jack just outlined.

MR. ASHBY: There's five different pieces. Do we want to go through them all or do we want to deal with them one by one.

DR. ROWE: That's my question.

DR. WILENSKY: Why don't we go through all of the information and then we'll take up the recommendations at the end one by one.

MR. ASHBY: All right.

I wanted to take a look at how we went about doing this impact analysis. This is the impact of the various option on Medicare inpatient margins. It compares a baseline margin with the margin that would result from the policy being implemented, costs held constant.

The baseline for this is the '99 actual margin adjusted for the change in disproportionate share payment

policy that was enacted through BIPA and has already gone into effect. That change, if we can review back to March, would increase rural hospital payments by 1.7 percentage points.

It was suggested at the last meeting that we examine the impact of the options on hospitals with margins below zero. We did take up that suggestion. So we defined a low margin group and a high margin group, the low defined as below zero and the high as above 12. You'll see here how those groups fall out. A much larger proportion of the rural hospitals are low margin than the inpatient, so we need to keep that in mind as we look at the impact on these groups.

The last thing I just wanted to say is that the primary purpose of our session today, of course, is to finalize our recommendations. But we also have a fairly lengthy draft chapter and this is an opportunity to make comments on that draft. If you have fairly minor or editorial comments, feel free to just give them to us so we can keep things moving, but there is the opportunity to

raise significant issues with drafting that need to be discussed.

So unless there's any questions, we'll get on with the first session, which is financial.

MR. KERNS: The first thing we want to do is update you with the rural hospital financial performance by degree of ruralness. While most of the analyses in this presentation will discuss the classic rural hospital groups, we wanted to bring you up to speed on these new findings, especially after Julian's presentation this morning.

This table shows three things. First, the Medicare inpatient margin is skewed in favor of the most urban and the most rural hospitals, which have the highest inpatient margins and the smallest proportions of negative margins. That the most rural hospitals had a margin exceeding 8 percent suggests that the existing special payment policies that seek to target isolated hospitals have indeed had a positive effect, at least on average, for these hospitals.

Second, the opposite story holds for the hospital

total margin. Although rural hospitals generally have higher total margins than urban hospitals, the most isolated rural hospitals are an important exception. They had the lowest margin at negative 0.4 percent.

DR. ROWE: Could you clarify whether total margin means total margin?

MR. KERNS: Yes, total margin, not Medicare. All payer.

DR. ROWE: Or total Medicare margin?

MR. KERNS: No, all payer.

DR. ROWE: And inpatient margins means --

MR. KERNS: Medicare inpatient.

DR. ROWE: You're mixing terms a little bit then.

MR. KERNS: There's only so much room on the slide.

DR. ROWE: So inpatient margin is only for Medicare, but total margin is for all payers?

MR. KERNS: You're right. That was originally in the title and to save space I took that out.

DR. ROWE: And total margin is all payer?

MR. KERNS: Yes, sir.

DR. ROWE: And inpatient margin is Medicare only?

MR. KERNS: Yes, but this gives you at least some idea of how they're performing under Medicare and then overall.

DR. WILENSKY: You could have done a total Medicare margin?

MR. KERNS: Yes. We have that, too.

DR. WAKEFIELD: You don't have outpatient care then?

MR. KERNS: No, but we could run that. I think the outpatient is going to look the same for all the groups, within a negative 15 and negative 20 it's being skewed.

DR. WAKEFIELD: [inaudible].

MR. KERNS: Yes, and I can do that. I could do that, there was only so much room.

To go with the story about the total margin, why that's interesting is that rural hospitals generally do have higher total margins. The fact that it doesn't work for the most isolated rural hospitals is a fairly important point.

The third point is that the inverse relationship of Medicare inpatient margins and hospital total margin suggests that although efforts to increase Medicare payments to hospitals in those areas appear to have had a favorable impact, they may not be enough to make up for other market pressures.

Large urban hospitals face the most financial pressure from uncompensated care and managed care while the most isolated rural hospitals may also face pressure from uncompensated care as well as from very low volume and difficulty in attracting skilled workers. These pressures underscore that the problems of these hospitals go well beyond Medicare.

MR. ASHBY: Okay, on to our first policy area, which is disproportionate share.

MR. DeBUSK: One thing before that, on the urban percent with negative total margin, is that from operations or is that from all sources of income?

MR. KERNS: All sources of income, including non-patient revenue.

MR. DeBUSK: See now there we get really skewed right there.

MR. KERNS: You're right. That does include non-patient revenue and everything else.

MR. DeBUSK: We need to be looking at operations, not income from other areas.

DR. WILENSKY: First, I think there's a question of whether we have the data for that. But the second is I think there's also a policy question, depending on what we want to look at, as to whether or not we want to look at total margins that show the financial well being at a moment in time of a hospital. We have total Medicare margin, which we're seeing. Or we have total margins.

Those are all valid numbers, but I think that there's nothing that is inappropriate about having a total margin, as long as you distinguish that's what you're looking at.

MR. DeBUSK: I understand what you're saying. But looking at these, when these are put together, to see what this would look like after the last three or four months of

the stock market, it would be a whole different look. But I've said enough, that's just an outlier.

DR. ROWE: The inpatient Medicare margin, that's a core Medicare payment? Or does that include DSH and GME and all the rest of them?

MR. KERNS: DSH, GME, IME, they're all netted in there.

DR. ROWE: So we're not really comparing apples to apples here. Those are special payments.

MR. KERNS: On the urban side, for sure.

DR. ROWE: Totalling rural, also. That's why the 8.4 is there.

MR. KERNS: That's why I said the --

DR. ROWE: That's special payments.

MR. KERNS: The efforts to reach those hospitals appear to have made a real difference.

DR. WAKEFIELD: What did you say, Jesse?

MR. KERNS: That the totally rural inpatient margin does reflect the efforts to send special payments to those hospitals, such as sole community and critical access.

Well no, critical access wouldn't be because it's not in the database.

DR. WAKEFIELD: I'd just ask you again if some point in time we could have the outpatient data on this, too, for rural hospitals.

MR. KERNS: Yes, absolutely.

DR. WAKEFIELD: To me, that's at least as important as inpatient margin. Total margin, that Medicare margin --

DR. ROWE: We have that in the chapter.

MR. ASHBY: We didn't bring it up today, Mary because it was just a matter of focusing where the action is. The outpatient doesn't have anywhere near the variation that the inpatient does.

MR. KERNS: Jack is definitely right.

DR. WILENSKY: Again, this chapter is inpatient. We have a chapter that we will be dealing with tomorrow that is outpatient.

DR. WAKEFIELD: Right. It's the total margin all payers that led me to ask for that.

MR. KERNS: I could get those numbers for you, Mary. That's going to be part of our output. Any other questions?

MR. ASHBY: On to disproportionate share. If we can look at this first overhead, this is the draft recommendation. It's the same one that we had up at the March meeting. But to review the history just very briefly here, we have a MedPAC proposal on the table, of course, that would equalize payment rates between urban and rural hospitals in addition to bringing incomes in care into the low income shares used to distribute monies.

Congress partially implemented that recommendation. It at least equalized the eligibility requirements for DSH but capped the DSH add-on at 5.25 percent for rural hospitals, whereas there is no cap on the urban side.

This recommendation would essentially represent a second step in reforming DSH. Not the full thing, but a second step. The BIPA change eliminated about one-third of the discrepancy between urban and rural. This change would

eliminate about two-thirds of the discrepancy between the two groups.

Looking at the impact table on the next slide, I wanted to highlight just two things here. First, the proposal would raise payments in rural hospitals by 1.4 percent, and there would actually be an increase of similar proportions for urban hospitals with less than 100 beds, but there are so few of them that, as you see, the urban impact actually rounds to zero.

Secondly, I wanted to point out that the largest increases would go to the last two groups. These are the rural hospitals that don't currently benefit from any of the special payment provisions that are on the books. We think this is a good outcome, really. It's an equalizing, leveling the playing field kind of an outcome.

But that's a lead-in to the next table, where we see sort of a different outcome. Unfortunately, we see here that at the individual hospital level, the targeting is not the best. The increase in payments is actually a bit greater for high margin rural hospitals than low margin

rural hospitals.

That speaks to the problem of continuing to base disproportionate share on low income shares that don't reflect uncompensated care and, in essence, speaks to why it's important that we stop short of eliminating the cap all together.

We did do a simulation similar to this two years ago of our full proposal that does bring in uncompensated care. And there we found a very different outcome. It did indeed raise payments for the low quartile by margins considerably more than the high quartile. So this sort of emphasizes that it's a useful step but it does not take it us all the way to where we need to be.

So that's the picture on the DSH recommendation. I guess we would probably want to take questions at this point, or should we just continue straight on?

DR. WILENSKY: I think we ought to continue, and then before we get to the discussion on the psych hospitals, go back and take each of these recommendations up, in terms of either modifying or voting.

MR. ASHBY: All right, then the next is low volume adjustment with Craig.

MR. LISK: I'm going to talk about the small scale operation section of the report and the potential recommendations you can make. This first table here shows the overall financial performance, both Medicare inpatient PPS and total margins for hospitals if there is total discharge volumes.

As you can see, hospitals with less than 200 discharges and those with under 500 discharges both had negative margins on the inpatient side and actually also for total margins with essentially, more than half of these hospitals having negative inpatient PPS margins and actually also on the total margin side of things. So their financial performance is overall worse than higher volume hospitals.

DR. ROWE: This is all payers total.

MR. LISK: The total margin is all payers; correct. So those numbers are actually pretty large, in terms of the proportion of hospitals that have negative margins. Again, these are low volume hospitals and this is

including their total overall business, as well. So it's just not the inpatient care.

If you recall previously, we did discuss that inpatient care is not necessarily a large share of these providers' business.

So we have a recommendation and we presented the information to you before on what a low volume adjustment, in terms of what the relationship between low volume and patient care costs are. We have a potential recommendation, it is that the Congress should develop a graduated adjustment to the rates used in the inpatient prospective payment system for hospitals with low overall discharge volumes.

DR. ROWE: Low would be less than 500?

MR. LISK: Low would be less than 500. What we did for a simulation is something that's similar to the overall relationship. It was something that's relatively simple.

DR. ROWE: You have that curve.

MR. LISK: Essentially we did though actually a

straight line, from starting at a 25 percent adjustment for the very lowest going to zero once a hospital reaches 500. So we did it just for simplicity, there's different alternatives that could be done. But that's what we ended up modeling.

So given what we modeled, the next slide shows the potential --

DR. WILENSKY: I want to raise an issue. I assume it will come up on a number of times. It's going back to this inpatient Medicare in total margin. I'm finding this -- it's not obvious when you pick up the table what you're looking at. You've got to label Medicare inpatient and total margin AP, all payer.

MR. ASHBY: We will make sure that is clear in the report. We can at least say that every table from here on out will be Medicare inpatient margin.

DR. WILENSKY: Just because when normally you'd pick it up, you'd think you'd be looking at Medicare inpatient, Medicare total, or total inpatient or total total, and it was not at all obvious that you do Medicare

inpatient and then total all payer.

DR. ROWE: Your glee, Jack, with the fact that all the tables will be Medicare inpatient reminds me of the fact that we tried to kill the concept of Medicare inpatient a couple of years ago [inaudible] because we thought it was misleading and we should use at least the entire Medicare rather than just Medicare inpatient margins. So maybe we could, when we get to the chapter, make sure we include at least a total Medicare margin.

It seems to me one of the problems we have is the unit of analysis. Maybe if we get the Medicare inpatient margin right for all hospitals, somebody says well what about the inpatient cardiac margin or inpatient ESRD margin? We're always going to find something that's unequal.

MR. ASHBY: On the other hand, for the purposes of viewing the impact, we sort of thought the inpatient margin was the best way to see the impact, because after all this is an inpatient payment system. The broader is important perspective, but this is what we first and foremost want to look at, is what is the impact on the payment system we're

trying to design there?

DR. WAKEFIELD: Could I comment on that? I think I kept using the terminology of patient and I want to make sure Jesse doesn't go off in a direction that I wouldn't have intended him. What Jack just said, I think it got me back on the right track.

What I was interested in was what I think you termed most of Medicare, the MOM margin, about a year ago. That's what I was asking for. That's what we were asking for, I think, at the commission starting about a year ago, which would be most to have reflected here.

Take out my request for outpatient, I was interested in that broader category. My apologies.

DR. NEWHOUSE: Jack, I'm not sure I agree with what you just said in response to Jack, that what we should be interested in is the Medicare inpatient margin, or total Medicare or total total.

I would agree with you if it were something that affected the weights or relative prices for inpatient care. This is basically an add-on that goes to the hospital to use

as it seems fit, in a sense. For that, it seems to me --

MR. ASHBY: For disproportionate share, particularly.

DR. NEWHOUSE: DSH is what I mean specifically. For that purpose, it seems to me, a total, one or the other of the totals is what's relevant. Probably the total --

MR. ASHBY: Yes, you're absolutely right, DSH is different in that sense.

MR. LISK: Moving on. This is the recommendation. What I want to now go over is generally the impacts of implementing low volume adjustment. I have three sets of margin tables. Again, as Jack said, these are inpatient margins and we have what is the baseline margin and what is the margin after the policy change.

The net effect, though, is of a low volume adjustment as we modeled it is the amount of payments that would go for this. And this is not budget neutral, so the 0.0 actually rounds down to zero. The amount of money put into the system for this would be roughly $22 million to fund the low volume adjustment. It would increase payments

to roughly 10 percent of the hospitals, in terms of doing that, without any access criteria.

So the amount of money that we're talking about is relatively small, so when you look overall, in terms of increases in change of payments for aggregate rural hospitals, we're only seeing a .2 percent change, for instance. But you see a slightly larger change for Medicare dependent and other rurals that are less than 50 beds.

About a quarter of low volume hospitals that are receiving hospital specific rates under the sole community hospital program or Medicare dependent hospital program, would start receiving PPS rates under the low volume adjustment. So the new PPS rate would be higher than the hospital specific rate for those providers.

Moving to the next slide, though, this is where we show what more of the impact is on the inpatient margin for low volume providers. So we only see the effects here of the hospitals with less than 200 beds and 200 to 500 beds. As you can see, the inpatient margin goes down from 16.4 down to 5.7 percent for those with less than 200 beds.

There's 11.2 percent --

DR. ROWE: Discharges, not beds.

MR. LISK: 200 discharges. Less than 200 discharges, thank you. As you can see, there's 11.2 percent change for that group as a whole and 4.8 percent, about 5 percent, for those between 200 and 500. That does dramatically improve their margins, as you can see.

DR. ROWE: That's the same, $22 million?

MR. LISK: That's still the same, just $22 million; correct.

DR. ROWE: So it's really a small number of hospitals.

MR. LISK: It's a small number of hospitals. It is roughly 10 percent of hospitals would see an increase in their payment here, though. So it's a small number, but it's a relatively big impact. This has been mentioned before, in terms of what's the improvement in terms of how many would be brought above zero in terms of negative margins.

Still, the majority of those hospitals with under

200 discharges would still have negative margins. Of those with the 200 to 500 discharges, where 50 percent had negative margins, it would be brought up to only 37 percent having negative inpatient margins.

DR. REISCHAUER: Are you making the adjustment you talked about, where the two low volume hospitals right next to each other, counting them as one?

MR. LISK: No, we're not. This is not providing any access criteria involved. This is just doing the adjustment, whether you're low volume. Now I'm going to report on something about that in just a moment here. Maybe that's a good transition for this. It's not a slide.

MR. SMITH: One question. I just want to make sure I understand what we're looking at here. The baseline Medicare inpatient margin on the slide that you just showed for less than 200 discharges is 16.4.

MR. LISK: That's different from the margin on the previous chart. That is because one is what is the '99 margin and the other is we're simulating 2001 payment policy with the DSH changes and other changes that were made as

part of BIPA. So that had a net effect of increase the margins slightly.

MR. ASHBY: It just adds in payments that they've already received.

DR. ROWE: Does BIPA have an effect here? Is this pre-BIPA, post-BIPA?

MR. LISK: This is post-BIPA but in reality the hospitals are pre-BIPA in terms of how they're actually operating, in terms of the...

DR. REISCHAUER: There's no BIPA behavioral response.

MR. LISK: There's no BIPA behavioral response, correct.

DR. NEWHOUSE: We don't know.

MR. DeBUSK: If we're going to take -- that $22 million change affects your less than 200 and 200 to 500, why would you not pool the lowest one there, less than 200 discharges, up to at least where it was a break even?

MR. LISK: That would be an issue in actually developing what you had. That's one of the options between

bringing a cost-based system -- you know, paying based on cost versus providing an adjustment like this, as well.

DR. ROWE: Don't get trapped here, Pete. This is just the inpatient. The smaller the hospital is, the greater proportion of the hospital's activity is non-inpatient. And until they show you what the total Medicare margin is for those hospitals, you don't...

DR. NEWHOUSE: Also it may be across the street from another hospital.

MR. ASHBY: Rest assured though that when we do go to total Medicare, it will still be negative.

MR. LISK: I don't have a slide on this but in terms of talking about across the street from other hospitals, we recently got road mile distance measures in, in terms of saying how many of these hospitals are X miles away from another hospital. What we reported in your paper were air mile distances, and now we have road mile distances. Unfortunately, I don't have a slide on this. But I can give you the basics on this.

For the hospitals that are less than 15 miles

apart, 14 percent of the low volume hospitals are less than 15 miles from other hospitals. So 86 percent are more than 15 miles, so are a fair distance from another hospital. In fact, 51 percent are more than 25 miles distant from another hospital.

So that gives you an idea that a large portion of these hospitals are not close, using a 15 mile standard for instance, to another hospital. So I think that's important to bring up.

The next slide shows low volume impact on the low margin hospitals and the higher margin hospitals. Here we see small changes for that group overall. But again, since they make up such a small portion of all these hospitals, you're not going to see big changes here.

DR. ROWE: Jack said that, rest assured it would still be negative and I want to see, if we brought -- what did you mean by it would still be negative.

MR. ASHBY: In the end, you see that -- actually it was on the previous chart -- that in the less than 200 discharge, even with the adjustment, they still have a

negative inpatient margin. My comment was if you brought in the other services, so you had total Medicare rather than just inpatient, it would definitely still be a negative. The other services are not going to raise their margins.

DR. ROWE: That's my question.

MR. ASHBY: That we know.

MR. LISK: The other aspect with hospitals with negative margins, for those that we classified as totally rural hospitals in the previous slides, the number with negative margins would drop from 35.5 percent to 25.8 percent. So we would reduce that proportion quite substantially, in terms of that group that has negative margins.

DR. WILENSKY: I'd like to remind the commissioners that apropos our earlier discussions, what we have talked about are strategies that Medicare can adopt that are reasonable Medicare changes that would also have a beneficial effect on rural hospitals.

So to the extent that we have seen presented information that suggests that low volume hospitals have

costs that are different from, scale effects that are different from the other hospital structure, there is a good justification for making a low volume adjustment.

But it would be at least very contrary to the notion of saying shouldn't we just wipe out any negative margins, whether we're talking about total margins or inpatient margins, again to try to make the distinction that we're trying to fine tune the Medicare payment strategies in ways that better reflect costs, and that we can use in good conscience to justify under Medicare changes. And to the extent that we think there may remain policy issues that are appropriate for the Congress to think about, that would assist rural areas that go beyond Medicare, we ought to regard them as separate.

We have stated that, but I think we're sliding back into this problem, when we talked about why we didn't get rid of all the negative margins.

MR. LISK: So the next slide, you may want to consider having a recommendation on an access requirement,

and that's what this slide provides that recommendation for, in terms of the Congress should only apply a low volume adjustment to hospitals that are more than a specified number of miles from another facility providing inpatient care.

We simulated the less than 15 mile criteria and that would reduce the total payments going to low volume hospitals to about $17 million. In terms of the proportion of hospitals affected, it would reduce the number by 14 percent basically.

DR. WILENSKY: We'll come back to discuss this. It seems like a lot of trouble for 14 percent of the hospitals.

MR. LISK: Thank you.

MR. ASHBY: The next is wage index related issues with Julian.

MR. PETTENGILL: At the last meeting we started out by discussing why an accurate input price adjustment is necessary. And we also identified the particular problems with the wage index that need attention, which include

occupational mix differences, labor market size and boundary problems, the age of the wage index data, and the issue of whether the labor share may or may not be too high.

What I'd like to do this time is respond to some questions that were raised at the last meeting, by Jack in particular, and highlight the policy options under discussion and their consequences. And finally, review the draft recommendations you saw last time.

I'd like to start with these bar charts, just for fun. A lot of people had the impression that wage index -- wage rates are high in urban areas and low in rural areas, and that's certainly true. But there are also some rural labor markets where the wage index is high and there are many urban labor markets where the wage index is low. There's a lot of overlap here.

DR. ROWE: Which is correct, the one you're showing or the one that's in our packets?

MR. PETTENGILL: There's two. One of them shows the distribution of the wage index, urban and rural wage index values by labor market area. That is, it shows you

how many of the labor market areas are distributed at what level.

That's rural labor markets and urban labor markets.

DR. ROSS: They got reversed in your packet.

DR. ROWE: So this one is the second one in our packet?

MR. PETTENGILL: Right, and that's hospitals.

So that's the story. There are, however, more hospitals, more rural hospitals, toward the lower end than there are rural labor markets to the low end. And the urban hospitals, correspondingly, are more concentrated at the upper end.

Let's talk about options for dealing with occupational mix. This is mainly where the action is, I think, at the moment. People have identified a number of different options. One, in the longer run, use occupational specific wage data. That's something that HCFA is working on, and presumably will be available three or four years down the road.

In the short run, people have talked about establishing a wage index floor, for example at .9, .92, .925. Compress the wage index by raising it to a power of less than one. That is, drag it in from both ends. Complete the phase out of the existing wages for teaching physicians, residents and CRNAs. Those are the three options, as far as I know, that are on the table.

The next overhead illustrates the effects of a floor and compression. You saw a version of this last time. This one differs only because I added a wage index value of above one to remind people that when you compress the wage index it comes up at the low end but it comes down at the upper end, as well.

The next table shows the proportion of labor markets. This is a question that Jack raised about what fraction of labor markets, hospitals and discharges would be affected by the floor? Well, if the floor were set at .9, 38 percent of the urban labor markets and 72 percent of the rural labor markets would have their wage index raised. Similarly, 23 percent of the urban hospitals and 87 percent

of the rural hospitals would have the wage index raised. Those rural hospitals account for 89 percent of all rural discharges.

So there was a notion, I think, last time that maybe this would be something that would only affect small hospitals. That doesn't appear to be the case.

DR. ROWE: Were you surprised by this?

MR. PETTENGILL: No. No, I'm not. If you're affecting all of those rural labor markets, they're all over the country. They're state-wide rural areas that have got everything in them.

DR. ROWE: The reason I ask is I wanted to make certain that if we were making a change in order to meet a policy goal, that it actually reached the institutions you're trying to reach rather than some [inaudible].

MR. PETTENGILL: Of course, it depends on what your policy goal is, but I think that the policy goal of the wage index, in general, is to make payment rates accurately reflect market conditions.

DR. ROWE: I agree with you that it depends on

what your policy goal is. We can interpret the introduction to the chapter as the policy goal is to equalize the Medicare inpatient margins. That would be one policy. It sort of depends on what your policy goal is.

DR. WILENSKY: Again, I think it's why we need to go back to where we started this morning, that what we are trying to do is to look at access to care, quality of care, for seniors in rural areas. And particularly to the extent that we can refine payment rates or quality assurance strategies that would improve either the quality or improve the access for seniors that we ought to make such recommendations as are appropriate.

To the extent that we think there are legitimate policy issues that are being raised in rural areas that go beyond Medicare, that we ought to reference other strategies for their resolution beyond Medicare. I think that's one of the issues that we keep tripping on.

DR. REISCHAUER: On the hospitals, 87 percent being affected, have you taken out the ones that have gotten reclassified? And if not, what fraction of all rural

hospitals? Are we at 100 percent here?

MR. PETTENGILL: No, this is a really -- even thinking about the floor puts you in a very peculiar place when you start talking about reclassification because as soon as you put the floor in, you're going to have a lot of hospitals that reclassify. And now they have no reason to reclassify, so presumably they would not longer reclassify.

We did not make any attempt to model that. Those are decisions that hospitals -- it's an application process. A hospital gets to choose what they're going to do.

If we had more time to play with it, we could take that into account. I'm sure that some fraction of the hospitals, perhaps a substantial fraction of the hospitals here, affected by the floor are hospitals that reclassified. There are 490 reclassifications in 2001 and the vast bulk of them are rural hospitals.

MR. HACKBARTH: We're looking at imposing a floor or compression as options because the true fixes are all out in the future, of fixing the occupational mix problem or the labor market definition?

MR. PETTENGILL: Right.

MR. HACKBARTH: That's the context for looking at this? There isn't any particular reason for imposing a floor based on the way the index is calculated, that we need a floor?

MR. PETTENGILL: That's right. Actually I think that brings up two interesting points. One, is that if the problem you're trying to fix is occupational mix, what will happen is if you used occupational specific data, the values for some labor market areas that have major teaching hospitals with lots of teaching positions and residents and high paid staff of all kinds would come down.

And because the wage index is calculated, any change in it is budget neutral. The wage index values for the remaining markets would come up, but not very much for the most part. So if you're going to take the wage index value for a market from .75 up to .9, that's a much bigger change than you would ever get from occupational mix differences.

The second point is that if you're going to fix

the labor market areas, which by the way I don't think is going to happen any time soon because it's a really difficult problem, then if you -- what fixing the labor market areas means is taking these big areas and cutting them down so that they really represent hospitals that are competing for the same pool of labor.

If you did that, what you would do is isolate a lot of the hospitals that are located out a way from the cities, which are not now isolated. Those hospitals are counted in the same labor market area, state-wide rural area, and the current wage index shelters them. It's higher than the wage rates they're actually paying.

If you narrow the labor market area definitions, what would happen is their wage indexes would go down. And in many cases, they would go down substantially.

So what problem are we trying to fix here? Does the floor take you in the right direction? It doesn't take you in the right direction for the more isolated rural hospitals. It takes you in the wrong direction.

For the hospitals that are near urban areas and

have higher wage rates, perhaps the floor takes them in the right direction. I don't know. Does it take them the right distance in the right direction? I don't know. You'd have to know what the new labor market areas would look like in order to answer the question really.

But I do know for the more isolated hospitals you're going the wrong way.

DR. WILENSKY: I think the more relevant answer is it was raised as a policy option because it's been put on the table. It's hard to imagine on a pure policy ground, even with the difficulties, that a floor would be the response, that the floor would be the policy response. I think that we strongly agree that we need to improve the definition of an appropriate labor market and we need to include the occupational mix. We support that. But it would be hard to imagine the policy justification for using a floor on the wage index. We'd have some serious questions about whether we're overshooting the appropriate level, the likelihood of getting it back from the appropriate level once you set a floor strikes me as about somewhere around

zero.

DR. ROWE: How do we reconcile that, Gail, with the fact that we have recommended or the Medicare program or somebody has recommended floors in the Medicare+Choice program for counties and things like that.

DR. NEWHOUSE: We didn't recommend that.

DR. WILENSKY: I believe that we not only didn't recommend it, but we're now on record in our recommendations and discussions as saying that we believe that the direction that we've gone in moves away from budget neutrality on the part of government between traditional Medicare and Medicare+Choice.

So while obviously Congress will make the decisions that Congress believes is appropriate, I think that the Medicare Payment Advisory Commission ought to make the recommendations that it believes are consistent with the structure that we set up.

DR. ROWE: I guess what we should do then, if there's a statement about the purest or the theoretical perspective on the floors, I guess if Congress is going to

be reading this, or whatever, I guess there should be some indication to say that notwithstanding MedPAC's position with respect to this, there are some elements in the Medicare program that use this kind of a thing. Do you know what I mean?

What is HCFA's response to your -- I'm not an economist. What does HCFA say in response to your or our position about floor as a bad idea in Medicare+Choice? Are they against it, too, and just Congress did it?

DR. WILENSKY: I suspect it would depend on who you asked. I think that the fact that Bob Reischauer and I, who are sometimes in different places -- although not all that often -- in terms of recommendations, we're very consistent on the problems that you've raised in Medicare+Choice by trying to respond to geographic disparities by minimizing or lowering geographic disparities in introducing larger disparities between a single market.

I thought that both the chapter and the executive summary very appropriately indicated the problems. My presumption, unless the commissioners choose to move away

from it, is that a wage index floor is not consistent with where we've been and where we will be in the future. This is a policy decision that Congress may choose to make for redistribution purposes to the rural hospitals, and that's their choice.

But on grounds of including Medicare payments, it's hard to get there.

MR. HACKBARTH: I'd feel comfortable with that basic reason. I'm also troubled by the possibility that if we put in a floor and then we get the data to do occupational mix, it goes in the opposite direction and we've just really made a hash of the whole situation.

DR. NEWHOUSE: That same logic could be applied to compression. It may overcorrect.

DR. WILENSKY: Yes, I think all the comments that we made with regard to the floor are equally appropriate for compression.

MR. PETTENGILL: The next chart shows the extent to which the floor would affect hospitals with low margins, low PPS inpatient margins. You can see that it would affect

a fairly substantial proportion of hospitals with low margins, 24 percent for urban low margin hospitals and 78 percent for rural. And that the changes in the wage index and in PPS payments would be pretty substantial on average.

That's perhaps not surprising, but what's also interesting is if you look at the next chart you see the fraction of high margin hospitals that would be affected by the floor. And those numbers are pretty large, too, 18 percent for urban and 84 percent of the high margin hospitals for rural would be affected. And the changes in the wage index would be even bigger.

The next one shows the -- we modeled this without budget neutrality because I presume that the proposal on the table in certain places is to use new money. So we modeled it without budget neutrality at a level of .9, just because we're stubborn. These are the results.

You can see that it would raise payments 3 percent for rural hospitals on average. When you get down into some of the smaller rural hospitals, the percentage changes would be larger, 5 percent, 5.1 percent. And of course, it would

raise their margins substantially.

The next chart shows the same kind of information for low margin and high margin hospitals. And there's nothing surprising about any of this.

MS. ROSENBLATT: What's the dollars?

MR. PETTENGILL: I don't know. I honestly don't know. Murray told me, we don't make cost estimates.

[Laughter.]

DR. WILENSKY: The fact that this is not budget neutral, I think we absolutely need to include some idea of how much money we're talking about in this non-neutral world.

MR. PETTENGILL: Okay.

DR. REISCHAUER: The other one was $22 million.

MR. PETTENGILL: This is substantially --

DR. WILENSKY: Because you can't talk about doing this without saying how many billions are we talking about here.

DR. ROWE: This is not budget neutral.

DR. WILENSKY: This is new money.

MR. PETTENGILL: Jack says about $500 million.

Compressing the wage index has many of the same difficulties. It's just that in addition to that it would reduce wage index values inappropriately at the upper end and there's little reason to believe that compression would, in the end, end up improving the accuracy of the wage index or the accuracy of Medicare's payments under PPS. The impact table for compression is on the screen.

This one, the overall impact here is very small because you're bringing down wage indexes at the high end and raising them at the low end to some degree. And in this case, we estimated it with budget neutrality because a change in the wage index of this nature would, unless Congress changed the law, would be budget neutral. But it has exactly the predictable effects. It would reduce wage indexes in payments for urban hospitals and raise them for rural hospitals. Although it depends a lot on which urban hospitals you're talking about, because some of them are in low wage areas.

For low and high margin hospitals, that's on the

next overhead, you would raise payments for both low margin urban and rural hospitals and lower them for high margin hospitals on average. But of course, the effects here are really pretty individual. You're going to get very different effects. For some low margin hospitals they're going to go up and others they will go down, actually, because low and high margins are not associated with the wage index.

The last option is completely --

DR. REISCHAUER: I just have a question about these. These margin percentages that you give are weighted by size? Or are they hospital averaged?

MR. PETTENGILL: They're dollar weighted.

DR. REISCHAUER: They're dollar weighted?

MR. PETTENGILL: Yes. They're aggregate margins.

DR. REISCHAUER: The cost estimate for the other one was $308 million.

MR. ASHBY: Could I just interject for a moment? I was mixing up my large options here. This is not the $500 million one, this is the $700 million one.

DR. REISCHAUER: No, it can't be. If the numbers are right, the .2 percentage point change in rural margin is $22 million, then --

MR. ASHBY: Yes, but there's a big rounding effect there, on the .2 percent.

DR. REISCHAUER: You're doubling what I'm saying. That's big, big rounding.

MR. PETTENGILL: We will get you hard numbers.

DR. REISCHAUER: It's big.

MR. PETTENGILL: It's big, yes.

The last option was completing the phase out of wages and hours for non-PPS activities, teaching physicians, residents, and CRNAs. The impact table for that, there's no chance of going too far with this one. Occupational mix adjustment would do the same thing, only a little bit more.

This again is budget neutral. I don't know where we got minus 0.0. We would be reducing payments slightly, .1 percent for urban hospitals and raising them .3 percent for rural hospitals with slightly bigger effects for some categories of rural hospitals and with corresponding changes

in the margins. For low margin hospitals we'd be raising payments and margins, but only slightly, and reducing payments and margins slightly for high margin hospitals.

The next overhead is the draft recommendation language. This is the same as the language you saw at the last meeting, saying essentially the Secretary should fully implement the policy in 2002, rather than continuing the phaseout over the remaining three years.

The remaining issue, since we don't have much that we can do about timing of the wage data and there's nothing we can do about the labor market areas in the short run, the remaining issue is dealing with the labor share.

One point about the age of the data. There are a lot of people, a lot of anecdotes, a lot of press about the shortage of nursing personnel these days, and a lot of people have worried about the consequences of shortages and if providers have to raise their payment rates and so forth it won't show up in the wage index for four years.

Really whether that's a problem or not depends on whether it affects different areas differently. If the

shortage is widespread across the country and everyone has to raise their wage rates, it won't change the wage index because it's relative. And it becomes more of an issue of what sort of an update you would have to give to recognize the change in market conditions.

But in any case, there's not much we can do about the timing of the wage index data, even if the shortage problems are geographically spotty.

DR. ROWE: Just following up on that. I think that's an interesting observation. Do we know if the purported or alleged shortage is local or variable? Or is it general?

MR. PETTENGILL: I don't.

DR. ROWE: Is it worse in rural areas than urban areas or vice versa? Do we know?

DR. WAKEFIELD: I haven't seen rural versus urban breakdowns. We've got data from across the country, state data and then regional data, national data from the national sample survey but I don't believe I've seen rural versus urban data, only anecdotal. And that anecdote is pretty

significant on rural hospitals.

MR. PETTENGILL: But you would hear many anecdotes out of urban hospitals, too.

DR. WAKEFIELD: Absolutely.

DR. WILENSKY: One would assume that the inner-city shortages, the difficulties may be worse. Any of the institutions that get stressed at all probably are going --

DR. ROWE: Are less able to pay higher salaries. The hospital with higher margins would presumably be better able to respond to this kind of challenge.

DR. WILENSKY: That would be your guess, but I have not seen any data on that.

DR. ROWE: The ones that have some money left over at the end of the day.

MR. PETTENGILL: Options for the labor share. We talked about the possibility of -- we raised questions about whether all of the components currently included in the labor share really should be there. We don't know the definitive answer to that question. Certainly, I don't. And so the recommendation basically asks the Health Care

Financing Administration to go back and take another look. They haven't updated the wage to the market basket, which is where this information comes from, recently. It's about time to do that.

So the recommendation is not for them to take specific action that would affect payments necessarily. It's to go look and see whether the weights included in the labor share are still appropriate.

Just to give you an idea of what it might mean, we made up a scenario in which the labor share would be reduced from 71.1 percent to 67 percent. But that's just an illustration. That's not because we think it really would end up being 67 percent.

Again, there's nothing that says that this would be budget neutral, but in fact at 67 percent it comes out close to budget neutral. It would reduce payments somewhat for urban hospitals and increase them for rural hospitals. And you can see the numbers in front of you, for low margin hospitals it would raise margins slightly, at least in rural areas, and reduce them slightly in urban high margin

hospitals, but raise them in rural high margin hospitals.

DR. ROWE: It would raise the margins --

MR. PETTENGILL: Would raise payments for high margin rural hospitals, yes.

DR. ROWE: High margin hospitals. If the baseline margin is 22.7 you're giving them 0.5 more, why does the margin go down?

MR. PETTENGILL: Must be an error.

MR. ASHBY: No, it's not an error.

MR. PETTENGILL: Actually it doesn't have to be.

MR. ASHBY: No, it doesn't have to be an error. Sadly to say, the answer to that is that there's a different sample used for the middle column than the right column because not all the hospitals have reported on the margins data. But our change in payments is based on a 100 percent sample of hospitals. So we get a little bit of bias. The one to pay attention to is the middle column, and that one is completely accurate.

DR. ROWE: So how much would we redistribute if we did that? We had $22 million, we had $300 million, we had

$700 million, and now we're up to?

DR. REISCHAUER: I confess, Jack is right, because I left out the urban and the urban went up in one table and not the other.

MR. ASHBY: In terms of the additional spending altogether, which is the kind of number we're talking about here, almost nothing.

DR. ROWE: But how about redistribution?

MR. ASHBY: It is budget neutral, so there's no increased spending.

DR. ROWE: How much would you redistribute?

MR. ASHBY: I don't know. We would have to go back and calculate that. The answer to that is buried in some massive printouts we have, but I don't know.

DR. NEWHOUSE: I'd like to make a comment on the logic here, if I could. It goes to actually the language in the recommendation that says, nearly always. I believe that Wall Street law firms charge higher rates than law firms in Dubuque. Now if I'm a hospital in Dubuque, I may sometimes use the Wall Street law firm. I probably more often use the

Dubuque law firm, but I don't know. The fact that Wall Street law firms and Dubuque law firms continue to exist doesn't to me imply that we should pull law purchases or lawyers purchases into a national index.

What we ought to do is, in principle, which is data we don't have, how often do you buy law services from high-priced or from major metropolitan area law firms rather than locally? Even if you did that 25 percent of the time, presumably that would fall -- by this recommendation you would now take all of the law -- the 75 percent you purchased locally and put it into a national index.

MR. ASHBY: But remember, if we took all of the suspect categories and made them all national we would end up with a 63 percent labor share. For simulation purposes we went with the 67 to represent exactly that notion. The answer is going to be in the middle somewhere.

DR. NEWHOUSE: But how do we know that?

MR. ASHBY: It's going to be somewhere between the top and the bottom.

DR. NEWHOUSE: It depends how broadly you want to

define the middle.

MR. SMITH: And purchases aren't going to be in the middle either, Jack. It's at least as illogical that a New York City-based hospital would purchase legal services in Dubuque as the other way around. So the skewing here is constant rather than moving toward a mean. Putting all of these things into a national marketbasket gets the skewing wrong on both ends it seems to me.

MS. RAPHAEL: You based this on asking national firms and they told you that they charged the same fee. That hasn't been my experience in dealing with technology companies, accounting firms, consulting firms, legal firms. My experience has been that the rates are very locally determined. But I just think that we need to do a lot more work before we could comfortably --

MR. PETTENGILL: That's why we didn't say change it. We said, go back and look.

DR. NEWHOUSE: But you did say, only includes costs nearly always purchased in local markets, implying that if you bought some non-trivial fraction in a national

market you'd put everything into the national index.

MR. PETTENGILL: How would you like to change that? Would you like to change it to generally purchased --

DR. NEWHOUSE: I'd just strike, nearly always; resources that are purchased in local markets.

MR. HACKBARTH: So you would actually split the category.

DR. NEWHOUSE: I'm not really sure the game is worth the candle at the end, but if you were going to do the policy thing I think that's what you ought to do. You ought to take the overall hospital. Things that are purchased locally ought to vary with the wage index and things that are purchased nationally -- now there's Carol's issue about rates. I don't know the answer -- that's a further question. My guess is, if we're literally talking about law firms, that the Wall Street law firm does charge Dubuque what it charges New York City, but maybe not. But there are probably other national firms that do vary their rates, and in principle that should be accounted for.

MR. PETTENGILL: Not only that, there are other

services included on the list that clearly are not local. If you buy computing services these days you don't -- you can get them from anywhere. And if you choose as a hospital administrator to buy them locally, that's no reason why Medicare should increase its payment for that if you can buy the same thing --

It's like hospitals that go out and buy drugs and they get them through a local organization and pay 30 percent more. Should Medicare raise its prices to accommodate that when the same supplies are available through a national market at lower rates?

MR. HACKBARTH: Today the labor-nonlabor split is drawn from the marketbasket. What is the test applied there? If this recommendation is nearly always, what is the analogous test in the marketbasket?

MR. PETTENGILL: That's a good question. I don't know. Basically the marketbasket has weights for all of the price indicators and those are developed from a combination of data from the Bureau of Economic Analysis, their input-output tables, and from AHA data, and there's probably some

Medicare cost report data in the mix. But in the end, I think it's a judgment about which weights are considered to be --

MR. ASHBY: I think there's another answer to that though. That is that all of them that HCFA has labeled local are local because they are driven by labor that is local.

MR. PETTENGILL: That's what their judgment is.

MR. ASHBY: Yes. So their judgment is that all of the items, if you will, whether it's a computer service or supplies or whatever, that they are all national. That is their judgment.

MR. HACKBARTH: But some of these are clearly a mix of local and national, like legal services. So they have to be applying some test, explicit or implicit, and say, this one's going on.

MR. LISK: Let me just clarify it. It's all labor-related costs, what they consider labor-related expenditures are then classified as labor related and then treated as though they are local. So there's no distinction

between local and national in terms of how HCFA develops that weight. They determine what is the labor-related share and that's what they apply the wage index to.

MR. HACKBARTH: So if it involves --

MR. ASHBY: If it involves labor, or if it's a product --

MR. LISK: If it involves labor, the wage index is applied to that share.

MR. ASHBY: It is still a judgment, and probably not overly accurate either.

DR. REISCHAUER: Can I ask another clarifying point about these tables? We have low margin and high margin. That doesn't exhaust the universe.

MR. PETTENGILL: No, we have the middle group as well.

DR. REISCHAUER: There's something in the middle and we're to presume that the effects on them are pretty minimal usually? We care about high and low and you're drawing a distinction, but if there was another panel that said everybody else and we saw a huge leap or fall in them

we'd be very concerned about --

MR. ASHBY: There wasn't, I don't believe, a single case where that was the situation. But we got into this to highlight the low margin hospitals. We put the high in there for balance I guess, but it's an arbitrary choice in a sense.

MR. PETTENGILL: To the extent that we put tables in the report they will have all three.

MR. ASHBY: The next issue has to do with the PPS base rates. The inpatient PPS currently has two base rates, one for large urban areas. That's areas with a population over 1 million. One for all remaining urban areas plus rural areas. This option is to raise the rural-other urban base payment rate to the level of the large urban.

You remember from our discussion at the last meeting that there are arguments both pro and con here and there is, at least in our assessment, no clearly correct answer in terms of improving the rationality of the system. So this is going to be kind of a tough choice.

The leading argument against raising the rural

base payment rate is that our multivariate analysis showed that costs are lower in rural areas after we control for wages, teaching, case mix, and so forth, the other factors accounted for in the payment system.

But at the same time, there's clearly another side to that coin. Our analysis also showed that there is no justification for the higher base rate that we already have for large urban areas. Costs in large urban hospitals are only higher in raw form. After you control for the other factors in the payment system they are not any higher than in other urban areas.

So equalizing the base payment rates would have a mixed result in terms of improving the accuracy of our payment rates. It would get it closer for some groups, farther away for others. So clearly one could justify either move.

But also on the pro side, one might argue that there is an inherent advantage in having a single base payment rate with then a set of targeted payment adjustments to account for factors that have a differential effect on

different groups of hospitals. As we've talked about at length, our ability to implement some of those needed adjustments is probably several years away, but that doesn't necessarily take away from the basic point that ideally one would want a single base payment rate adjusted as needed.

So there are, in our minds, three options here. One is to recommend no change, and that, as we say, might in part reflect our belief that the other recommendations that we are making will do enough to produce equitable payments between urban and rural and at the individual hospital level. To help inform your judgment in that area, we simulated the impact of several of the leading options that we've been talking about together so that you can see what the combined impact would look like. We'll get to that in just a moment.

Our second option is to defer the issue until at least the next cycle and we'd have more information on how rural hospitals and urban hospitals compare financially, and we'd also have more information on the option that we tabled, and that was extending the expanded transfer policy

to all DRGs and returning the savings to the base rates. Because that option is interesting to contrast against this one.

Both of these options would raise the rural base payment rate, and oddly enough, by probably similar amounts. The difference is that this option would in essence be paid for by large urban hospitals proportionately. The transfer option would be paid for by those individual hospitals that have to date profited by being able to transition their patients to post-acute care early in the episode. That would include, of course, some rural hospitals as well as many urban hospitals.

So one is simply a bit more targeted than the other in terms of funding a budget neutral option. Of course we don't necessarily want to rule out the idea that we would eventually want to do both, so we leave that one open.

The third option is to actually recommend equalizing these rates now. We could look at it as a permanent change or we could look at it as a temporary

change pending finalizing these other targeted adjustments. Of course, in Washington, temporary is sometimes measured in decades. But nonetheless, it in theory could be sunset at some point when we have completed other work.

Looking at the impact table, we've looked at this option budget neutral. Obviously it would not necessarily have to be. The main finding here is that this would increase rural rates on average by 0.5 percent. The 0.1 percent reduction on the urban side masks a decline of 0.6 percent in large urban areas -- they're the ones that are paying for this -- and an increase of similar proportion to rural among the other urban areas.

DR. ROWE: Do you know how much money that would redistribute?

MR. ASHBY: Again we didn't add it up, but a fair amount to be sure.

Lastly, wanted to point out that the 0.8 percent increase down in the bottom two groups is the full effect of this recommendation. The diminished effect among the other three groups that you see there happens because some of them

are paid outside of PPS and they are not affected by this change.

So to help you consider whether this is the kind of move that we would need to make we looked at the combined impact of four options that we've been discussing today. Let me say right off the bat, the four were ones that we thought might be leading options in your minds, but there's a whole bunch of different permutations of options that could have been analyzed but we didn't have a whole bunch of time to do this so we picked out a couple to represent the situation here.

So if we can look at the next overhead, the four that are included here, actually they're there; I don't think I need to read them. They're the ones that we have been looking at here. Two of these are, the wage related ones are redistributive. The last two, the DSH and the low volume are assumed as new monies for this analysis. Then the second combination we looked at are these same four plus adding in the idea of raising the rural rate.

So if we look at the table, the key finding here

is that the four policy options in combination would raise rural rates on average by 2.5 percent. You remember I said last time at the last meeting that the gap in inpatient margins and also the gap in total Medicare margins between urban and rural hospitals was about 10 percentage points. In the first column, the baseline already reduces that to eight points. That's the BIPA change that has already gone into effect. These four policy options together would bring the gap down to six percentage points.

Then if we go on to the next table and add in the last one we see, first of all, that the increase in the rural rates has gone from 2.5 percent to 3.2 percent, and the gap between urban and rural falls another percentage point from six down to five.

I guess I would add just parenthetically, if we did this raising the rural base rate not budget neutral it would reduce the gap down to four. And as we talked about last time, our goal was not necessarily to equalize margins here at all, but this is an indication of how much the gap would fall. Most of the remaining difference can be

attributed to the IME adjustment, and of course that's something that's firmly in place and we're not talking about narrowing that gap here at all. So that's the scenario.

DR. ROWE: And DSH to some extent.

MR. ASHBY: To some extent. But remember, we have a proposal for DSH that's in here that eliminates a lot of that difference. So some, but more limited.

DR. LOOP: On that combination 1-2 slide, you don't mean employed physician data. Don't you mean teaching physician hours? What is employed physician data?

MR. ASHBY: You're implying there's other kinds of employed physicians. Perhaps that was not the right word to stick in there, but same option.

DR. LOOP: But before you said teaching physician hours, because not all teaching physicians spend their time teaching.

MR. ASHBY: Yes. In any event, it would be measured --

DR. LOOP: Probably the minority of employed physicians actually teach at all.

MR. ASHBY: That's right. In any event, is it carried at the FTE that the teaching physicians actually are engaged.

DR. ROWE: It's the IME piece is what you're really talking about. It's the number of hours that physicians are dedicated to teaching as opposed to running the emergency room or the coronary care unit.

MR. ASHBY: Right. But to answer Floyd's question, it is carried in terms of FTE physicians. It's not carried in number of people involved, so it is accurate in that sense.

DR. LOOP: That same term is used in the text too, employed physician data. You probably ought to say something else.

MR. ASHBY: Clean the wording up there, okay.

DR. WAKEFIELD: Jack, what on combination 2 is raising that urban hospital rate from 13.6 to 13.8, the margin? What's raising that margin?

MR. ASHBY: That's the other urban. Remember, the base rate is for rural and other urban, so on the urban side

there's a mix of up and down.

MR. SMITH: And you didn't disaggregate, Jack, urban hospital where [inaudible] --

MR. ASHBY: No. We have that data. I guess we were just limiting the number of tables here.

MR. SMITH: Let me ask a question which I know we don't know the answer to, but we've asked a bunch of redistributive questions. What would be the cumulative redistribution of either of the policy packages? We don't which are big and which are little, or we know which are big and which are little. But it seems to me now they could add up to quite a bit. It would be important to know that before --

MR. ASHBY: I think actually it's fair to say that of the four options you're looking at there, only one of them really has a significant redistributive effect, and that's the labor share. So that's where the redistribution takes place. The other wage index is a real tiny change, although it's redistributive too. And the other two policies don't redistribute at all. So it's really little

more than what we looked at with the labor share alone. That's kind of where the action is redistributively.

DR. WAKEFIELD: Jack, just because you can tell me more quickly than I can find it. It's the case that we're suggesting if we adopt the recommendation dealing with the labor share that it be looked at, though the way you have it reflected here in this policy option is that it would actually be reduced; is that correct?

MR. ASHBY: We had to assume something in order to do a simulation. So that's where we came up with the 67 percent labor share, it was kind of in the middle. But as Joe pointed out, we have no idea whether the middle is the right place. We just had to assume something.

DR. WILENSKY: But let me make sure the commissioners understand. The point is really an important one. If we were to adopt package one, we are not saying (B) is actually what occurs. What we would be recommending is that the Secretary examine the difference between this national and local labor and make decisions that put them in their appropriate slot. And that it's only for purposes of

trying to get a sense of what it might look like that he's used this.

MR. ASHBY: Right.

DR. WILENSKY: So if you were to say, let's look at what we call combination one, step B will be what it will be after there's an examination of the national versus local labor distinction.

MR. ASHBY: We'll make that point very clear in the report.

DR. ROWE: So you're really changing (B) to reduced labor share rather than to 67 percent.

DR. WILENSKY: Or not even. It will be to evaluate the modification and it's only -- I think, correctly, for purposes of being able to simulate, you have to assume something. By taking it in the middle, we try to minimize the error. But in fact there's no reason to assume it would be in the middle.

MR. HACKBARTH: How much of the change described on the impact table is attributable to that assumption of 67 percent? That's a big piece of what's here, isn't it?

MR. ASHBY: No, I would say the biggest piece is the disproportionate share actually, which is not redistributive, and that's not budget neutral. I guess the labor share is sort of like the next one in line, if you will, but it's significantly smaller than the DSH.

MS. RAPHAEL: I just had a question about the low volume adjustment. If we moved toward a policy of implementing a low volume adjustment, does that mean that we would need to then consider it in other areas where there also are low volume issues?

MR. ASHBY: Right, I think that it is incumbent on us to continue the analysis in other areas. Next in line, if you will, would be hospital outpatient, without a doubt, an area that we should be --

DR. WILENSKY: I assume you are meaning non-rural.

MS. RAPHAEL: Yes, I was.

MR. ASHBY: I think it's worth emphasizing that. We didn't really see the low volume adjustment as being restricted to rural hospitals either. If there are other hospitals that meet the criteria, including the distance

criteria, there is no reason whatsoever to restrict this to rural areas.

DR. WILENSKY: Again, that's really consistent with what we said is our preferred strategy for making these fixes, is to recognize that we are not currently making an adjustment that would improve the payment by acknowledging that low volume institutions have higher costs. So although it would primarily affect rural hospitals, if there was a low volume institution is what is a non-rural setting, we'll presumably make the same kind of adjustments, and the same with the distance. This primarily is going to affect rural but it's not being done as a "rural fix."

MR. HACKBARTH: Help me sort out the rural and other urban base rate. The basic logic of the system is you have a base rate and then you adjust that for things that are beyond the hospital's control, whether mix of patients, its input costs, et cetera.

Here we have a difference in the base rate that isn't related to that logic. In fact it's an artifact of the system when it was first put in place, and the goal is

to limit redistribution. The original urban-rural differential was put in so that there wasn't too much money shifted around in the system. Gradually we got it down to this, to the rural-other urban differential. But that logic is based not on cost beyond the control of the provider but just a political rationale that we don't want to shift money about.

MR. ASHBY: I would say that's a fair statement.

MR. HACKBARTH: Now, Jack, in describing the logic behind it you said, we do simulations and we see that the costs are lower in the rural-other urban category.

MR. ASHBY: They're lower in the rural category. They're not lower in the other urban category. So that's why I say, the findings don't match the current system already. If there were to be a division, it appears that the right division is urban-rural which is where we started out way back at the beginning. But we wanted to phase that out. Somehow we ended up with this distinction between large urban and other urban, and that distinction does not appear to have any empirical base.

DR. WAKEFIELD: Could I ask a follow-up question? If I understood it correctly, Jack, did you also say that there was no justification for the higher base rate for larger hospitals?

MR. ASHBY: Large urban. That's not larger hospitals, that's large urban areas.

DR. WAKEFIELD: That's what I mean, large population hospitals.

MR. ASHBY: Exactly. The multivariate analysis does not support that distinction at all. There is no difference in underlying cost between large urban areas and other urban areas.

DR. WILENSKY: But there is between urban and rural.

MR. ASHBY: Right.

DR. WILENSKY: So the only question is really whether we do something about the other urban.

DR. WAKEFIELD: And if you do something about the other urban, what impact does that have on the urban?

MR. ASHBY: If you did something on other urban

alone it would have no impact, obviously. If it was budget neutral it would have a negative impact. But I guess we were assuming that we were not going there. That if we made any change at all it would be to get to a single rate, which has a certain intuitive appeal, to simplify the system. It would be one less border in the system if we had one rate here.

DR. ROWE: Just for the sake of trying to blind justice, if the data that we're given are correct, and if rural hospitals have consistently higher total margins than urban hospitals, why is it beyond thinking that you would actually distribute money from rural to urban? I'm not suggesting we do that, but everybody says, we can't go there. It seems to me that if in fact that data we're given are correct, that if that's something that we wanted to discuss, we should discuss it.

DR. WILENSKY: That's true of total Medicare margins.

DR. ROWE: No, total hospital margins.

MR. KERNS: That's not the case on the overall

Medicare.

DR. WILENSKY: We're trying to impact what Medicare is doing, and in the same dissertation that we didn't want to, or had some reluctance about making up for some bad decisions of the private sectors in urban areas, I don't know that we want to penalize rural areas for being able to cut good deals because of their positions in rural areas. What we're trying to do is get Medicare payment right and to make what are good Medicare arguments.

DR. ROWE: I accept that. I think that's the right answer. But for me at least, the difficulty in looking at this, Gail, relates to the fact that the factors that regulate the total margin of the hospitals sometimes are unlinked to the factors that are driving the Medicare margins of the hospital. Let me give you an example that I'm thinking of.

Many of the rural hospitals -- now I'm putting my health plan hat on. I have a lot of hats here, but this is the health plan hat. I'm serious about this though, and maybe the economists can tell me where I'm wrong.

The rural hospitals do very well with the health plans. The data and the figures in this chapter, the health plans pay the rural hospitals 140 percent of charges -- or costs, 140 percent of cost according to these data. I think they do that in part because the plans need to have access for their members to the hospitals, there's no competition, no other hospital so there's not really a market. That is a large part of making the total margin for the rural hospitals higher than the total margins for the urban hospitals.

Now if we say we want to raise the Medicare payments to make sure that the total margin for Medicare for rural is equal to that of urban or is equal to zero, that's not going to reduce the advantage that the rural hospitals have with the health plans. They're not going to stop getting 135 to 140 percent of cost. What's going to happen is the distance between the total margin of the rural hospitals and the urban hospitals is going to get greater because of this lack of -- I mean, that's what I see as somebody who's focusing more on the total margin.

So if we wind up doing something like this, and any one of these or more of them -- and I'm not commenting on any of these in particular, I was just thinking about this. That because of this effect we're going to wind up in two years coming back the difference between the total margins is even greater. We have to think of that as well as the Medicare program.

I think if these hospitals have high positive total margins then our Medicare beneficiaries are going to have access to these hospitals. The hospitals are going to be there, they're going to be sustained, et cetera.

DR. WILENSKY: But we still want to make -- to the extent that we make adjustments that we think -- to the extent that we make recommendations to change Medicare payment in a way that we believe improves the accuracy and validity of the Medicare payment, like making an adjustment for low volume because costs are higher in low volume institutions, that is something that we ought to be comfortable making because it makes for a better payment system. I think we ought to hesitate from making

recommendations purely because of the effect they have on margins if we don't believe it is an improvement to how Medicare pays.

Now at the end of the day when we have what we think are the best Medicare payments, if we think there are areas where there will be access problems for seniors, then we have a different issue. But I don't think we should not do something when we think it will make for a more accurate Medicare payment. Now the fact that it may alleviate what we think are some other pressures, fine.

But we really can make the justifications why -- I've tried to raise this several times during the day, is that, in my view, based on what we've said as a commission before, we ought to be looking at changes that improve Medicare payments. And we ought to look at the distributional effects between whatever groups that we think are relevant -- and this is supposed to be focusing on rural. So obviously the first question is, if we're making what we think is a better payment, what does it do for rural hospitals, and which rural hospitals, and how do we feel

about that?

DR. ROWE: I would only say, I accept that and I think it's consistent with what I'm saying also. I guess I would just complete my thought, Gail, by saying that I think that that's right but that in doing that and making those adjustments to improve the quality and fit of the Medicare payments, we should be mindful of the effects on the individual hospitals.

And since the groups of hospitals overlap so much in their characteristics with respect to how they're doing on these margins, Medicare or others, as Julian has pointed out, if the change you're going to make to target some of these identified inequities or weaknesses in the Medicare payments, irrespective of the effect it's going to have on increasing the overall margin of the hospital, is also one of redistribution -- of moving money from some Medicare hospitals to other Medicare hospitals -- that even further aggravates what I see as this overall margin effect because it lowers urban as it raises rural.

That doubles the effect. And I see that as

probably not worth the candle. It's kind of, above all, do no harm. That's different than some of these targeted recommendations that have come along that we've heard today which we'll get to, which are more targeted toward the real needs of the Medicare program toward some of the rural hospitals, rather than all of them.

DR. WILENSKY: Again, I think we're going to go through each of these recommendations and we'll have an ability to either accept or not accept the recommendation on its own merits. I think trying to look at, when we look at several of these in combination, what do we do or what impact that we'll have I think is fair.

MR. SMITH: I think the logic of what you and Jack just went through is right, Gail, but I think it's a mistake when we're looking at recommendations that are redistributive to think that our only metric of change ought to be rural hospitals.

I think part of what we need to be concerned with is the maintenance of the hospital infrastructure that provides support to Medicare patients. It's not obvious to

me that if we weaken it in urban areas by reducing total margins and improve it in rural areas by increasing total margins, that we shouldn't look at total margins, at the impact of the Medicare system on total margins to the extent that that has an impact on the stability and viability of the institutions.

DR. WILENSKY: I think that's fair. The fact is unless we're just talking about putting more money into the hospital area -- and we have, at least in terms of our previous recommendations believed that the current payment, payments in current law were adequate, that looking at some of these specific issues and seeing whether or not there's a better way to focus Medicare payments is an appropriate exercise.

I think that was why the impact on total margins for urban and rural, and if there are other hospitals that you want to look at we can at least try to provide you with that information in the interim, is appropriate. We're not just looking at how it affects rural, but we are giving more attention to how it's affecting rural. There are categories

to show otherwise.

Now we know that, or we all understand that in Medicare as we currently have it structured, that the DSH and the indirect medical education, the GME payments, produce very high Medicare margins which help have total margins that are at least in the positive range for the very large urban hospitals. I think we all realize that because, particularly of the function they play in the aggregate of the uninsured, that whatever our views about how effective a targeting mechanism that is, there is a particular relationship going on and we're not anxious to have a major change in the distribution.

One of the fortunate factors is that you can do more to change the rural because they're not only a small proportion of the hospitals but they tend to be typically small hospitals, so that in doing something that improves accuracy, that has some beneficial effect on rural, you're tending to have a very small effect on urban because of the relative dollars that are accounted for. I think it's fair to say if you're having redistribution, you ought to have

some idea about where you're redistributing from as well as where you're redistributing to.

MR. HACKBARTH: If there's a change that makes sense within the logic of the system that has a redistributive effect away from urban towards rural, I hope we'll go ahead and do the change --

DR. WILENSKY: I agree.

MR. HACKBARTH: -- because it's logical; it perfects, improves the accuracy of the payment system. If we get to the point though, Jack, where these changes have driven urban hospitals into financial distress, looking at the total margin, then I think the appropriate response is to take that into account when we do the update factor. Not to forgo improvements in the system because they have a redistributive effect.

I think that if we look at the total margin as sort of a fallback; yes, we have to assure there's an adequate infrastructure for our Medicare beneficiaries. But our principal responsibility is as a payer for Medicare. But we don't want to drive all the urban hospitals into

bankruptcy, and if we need to do something, let's do it through an update.

DR. ROWE: Let me respond though. With all due respect, I think we have different points of view because we've spent our time doing different things. I think your suggestion is, if we do this and it drives the hospitals into distress and financial crisis, then we will correct it with the update factor, is a policy-oriented, inside-the-Beltway point of view. As a guy who has run hospitals and had to fire people and close units and reduce services as I go into distress, only then to have Congress respond and two years later I get some more money so I can open the unit again, that's no way to run a community resource.

MR. HACKBARTH: But the rural hospitals would say the same thing.

DR. ROWE: I know they would. I'm not suggesting that this is urban versus rural. I'm just saying that the way to run policy, if we want to have sustainable resources for our Medicare beneficiaries to get access to high quality care is not to say, we'll do this and if you go broken then

we'll change and we'll give you some and we can resuscitate you. We need a sustained system. That's all. It's just a philosophical --

DR. WILENSKY: Let me try to remind people, first in terms of the relative magnitudes that we're talking about. I think people are getting totally off the base of anything we're talking about. We have been talking about relatively small changes that mean more for the rurals because they account for 20 percent of the hospitals and 10 percent of the dollars or less or whatever. I mean, we're talking about rather modest change.

The second thing is the kind of statements we made for the rural apply for the urban, which is that if at the end of the day we have had the best kind of payment policies that we can come up with and we think there may be problems, then we ought to feel comfortable about recommending non-Medicare solutions to address the problems. Now I don't think we are anywhere near that. I think people are getting into arguments and corners without thinking about the numbers that are involved here.

But just as we said several times about rurals, that there are things that are appropriate for Medicare to do, and there may be other issues that are perfectly appropriate for public policy that go beyond Medicare, certainly are appropriate to say for the urbans.

But what we're trying to do on the changes we've been talking about thus far is, is do what we believe are improvements. And to the extent that the policy issues come up which we don't think are justified on policy grounds, and some of the wage change, the floors and the wage indexes would fall into that category, then we think they're not appropriate policies.

I don't think we're talking about redistribution of the level that you're raising, but again I think that if we find that there's any change and we think any change has a negative impact on urban hospitals and it's Medicare's place to make sure there's no -- anything we do is budget neutral with regard to urban hospitals, that would put a burden that I think we have not held when we went the other direction.

MR. ASHBY: Can I interject here that we have two small potential improvements that don't necessarily increase rural margins as well still on the table that we wanted to go through too, when the appropriate point is --

DR. WILENSKY: We're going to come back to do each of these recommendations, so unless there's -- to review them. Is there something that you want to say at this point?

DR. WAKEFIELD: It was just basically the same points that you made, Gail. If you hadn't have made them, I would have made them, for the record. In the interest of time I'm deferring.

MR. KERNS: I'm just here to revisit one subject we spoke about at the last meeting and to raise one more. We have some new data that may inform your decision regarding the rural referral center recommendation we spoke about last month.

To refresh your memory, rural referral center receive waivers from two of the three rules for reclassification. One, they don't have to show proximity to

the area they want to relocate, and the second, they don't have to show that their wages are in excess of 106 percent of their actual area's wages.

If these hospitals really do employ a more expensive staff mix, as how the program was based so that they would have a higher staff mix, then their higher cost should result in wages above the threshold required for reclassification. We found that in 2000, 50 percent of rural referral centers that were classified to a new wage index had wages that were below 106 percent of their area's average, and therefore qualified for reclassification based solely on this special exception.

Based on the inequality suggested by these numbers, you may wish to recommend that the Congress require rural referral centers to make the same wage thresholds as other hospitals for reclassification, but retain their waiver of the proximity rule.

As a compromise measure, you could consider requiring that rural referral centers have wages that are at least above average for their area. We found that nearly

one in four, 23 percent, of reclassified rural referral centers, when they were sent to a new wage index had wages below the statewide rural average. So they were already receiving payments favorable to their facility's costs.

With this refinement, those rural referral centers that meet the rationale for different treatment, having higher resource costs, would continue to be reclassified, and those that don't would not.

This next one is the sole community hospitals. At the last meeting I reported that the critical access hospitals are not counted as like facilities, similar hospitals, in applying the 35-mile distance test for applicants to the sole community hospital program. With the steady increase in the number of critical access hospitals from 219 last fall to over 350 today and the promise of more to come, the Commission expressed concern that the number of sole community hospitals could also increase dramatically, and possibly unnecessarily.

We analyzed road mile distances to the next hospital and found that when we include critical access

hospitals only 45 percent of sole community hospitals are more than 35 miles from another hospital. The number of sole community hospitals increased by 75 in the last year, and it may begin to increase at a further rate. Right now nearly 1,200 rural hospitals, which is more than half of all rural hospitals, are either sole community or critical access.

In discussions with HCFA I've heard that the number of sole community hospitals could increase because there's a growing interest of hospitals calling in and asking about the rule, and hospitals wanting to collaborate together in application for these programs, et cetera.

DR. WILENSKY: But either we believe that the critical access hospital definition has some meaning, in which case they're not similar hospitals. I find that either we don't really mean that they're similar hospitals, or we think that somehow the critical access hospital is a phony distinction, in my view. That if these aren't really hospitals any more, they're medical holding centers. Then it strikes me that saying that you have in your presence a

medical holding center still means you're a sole community hospital, because by definition medical holding centers aren't going to be community hospitals. That's what they pledged when they became a critical access hospital.

MR. ASHBY: They still provide inpatient care there's just kind of a slow continuum of what inpatient care means that's very wide, and where to draw the line --

DR. WILENSKY: Clearly, the Congress decided they're not community hospitals, that's why they're giving them the special privileges of being critical access hospitals. We can argue about this. Either you don't believe that a critical access hospital is a real entity, or if you do then it strikes me that this isn't logically consistent.

Although I understand the concern that you're raising of, are these almost hospitals. If they're almost hospitals, we ought to be asking why we're giving them the special privileges of being critical access hospitals. So either you don't buy into the special support that critical access hospitals are given or it doesn't seem to me that

this really is supportable. You can decide which direction that you think is most appropriate.

MR. ASHBY: I think we're at the end of the list if we want to backtrack.

DR. WILENSKY: Why don't we go back to the recommendations. I apologize for making people wait so long in doing the recommendations but we frequently trip on the fact that it's coming later argument when we do them one at a time. The first has to do with disproportionate share. This, as you will recall, was to take at least one step further where Congress had gone on having a similar threshold but having a differential cap.

DR. ROWE: Could we have with each of these some understanding of the financial implications?

DR. WILENSKY: This is an add-on cost.

MR. ASHBY: Right, it's on the order of $180 million or so cost.

DR. WILENSKY: This was basically consistent with the recommendation that we made of which Congress adopted part.

MR. ASHBY: Right.

DR. WILENSKY: So we're effectively reiterating our previous recommendation, somewhat modified.

MR. HACKBARTH: When Congress went, I think you said a third of the way last time, was it just for budget reasons that they only went a third of the way or was there some other logic behind it?

MR. ASHBY: No, it was largely for budget reasons. We argued that if you have a cap on how much you can spend, better to at least make the qualifying criteria equal and cap it at the very high end. But in the end it was a budget decision.

DR. WILENSKY: Any changes to the language?

DR. REISCHAUER: Not to the language, but I presume our end objective is to eliminate the cap altogether at some point.

MR. ASHBY: Right.

DR. REISCHAUER: I would hope that in the text at least, or in the wording here, that it would say, for the time being raise this, rather then some --

MR. ASHBY: We tried to make that clear. This is taking us towards a final goal, and we're not forgetting the final goal.

DR. WILENSKY: Also the change that we want to have uncompensated care included as the appropriate trigger.

DR. NELSON: I wasn't here when the decision on the 10 percent figure was made. Why was it 10 instead of nine or 11?

MR. ASHBY: It about cut the difference one-third/two-thirds. There was also the thought that 10 percent is a figure that's already in law. That is the rate that is available to sole community hospitals which make up a third of the rural hospitals. So by making it 10 across the board we've at least created some consistency across all rural hospitals, until we get to the next step when there wouldn't be a cap at all. But even having said that, it's not like it's a scientifically determined, correct number.

DR. WILENSKY: Any further discussion on this?

All in favor?

All opposed?

All not voting?

Next recommendation? My understanding was it should read that Congress should require the Secretary to develop a graduated adjustment is the words that should be in there?

DR. ROSS: Yes.

DR. WILENSKY: So insert that phrase.

MR. HACKBARTH: Say again, Gail.

DR. WILENSKY: The Congress should require the Secretary to develop a graduated adjustment.

DR. ROWE: This is the $22 million one, right?

MS. ROSENBLATT: Is this with or without the miles?

MR. ASHBY: We were looking at that as a separate recommendation, but want to include that, too.

DR. WILENSKY: Is there a reason not to put them together?

MR. ASHBY: It was only the thought that there's two decisions here. One is whether the low volume concept

makes sense, and then secondly, whether you want to make it uniformly available or create an access to it. I think if you approve both concepts then it only make sense to go back and fold them back into one recommendation.

MS. ROSENBLATT: I was taking it as an either/or.

DR. NEWHOUSE: No.

MR. ASHBY: We had it as two essentially because you can have one without the other. But if you want both, then let's fold it into one recommendation.

MR. HACKBARTH: Put it as one, because I don't support the first one without the second.

DR. REISCHAUER: I don't want one without the other.

DR. WILENSKY: Is everybody comfortable putting the two together?

DR. WAKEFIELD: I have a question. Jack, what does this do to the discussion you had in the narrative about one option could be to split the low volume adjustment if you had two hospitals that were within somewhat the same area? Does that factor in here at all or no?

MR. ASHBY: Yes. We suggested that that was the way to handle hospitals that are closer than 15 miles. So if your recommendation has the 15-mile standard in it, then the backup language would explain that that's the appropriate way to treat those that are less than 15 miles. In theory, I guess you could bring that up to the bold level of the recommendation two, but somehow it seemed like more of a detail level for supporting language.

MS. NEWPORT: I'm not sure, maybe it's just we've been on this so long, but the weather conditions, is that defined already as something that's --

MR. ASHBY: Those are already built into law for sole community and critical access where we have mileage things. So I guess it was kind of a matter of bringing that up quick enough when you implement the standards.

DR. WILENSKY: But this is a phrase of art that's already in law.

MR. ASHBY: Right.

DR. WILENSKY: Is everybody comfortable then amending the recommendation that we just made to include the

qualifications of this?

DR. ROWE: Thirty-five miles apart.

MR. KERNS: It would be road miles.

MR. LISK: I think the only thing is whether you want it to be specific on a mileage or not, or just leave that as it is here in the discussion.

DR. WILENSKY: Are we comfortable in leaving the wording as it's there?

Okay, let me have a formal vote of all voting yes on this, as amended?

All voting no?

All not voting?

Thank you.

DR. ROWE: On this next one, I may have missed the discussion, but can you give me just a minute on the certified registered nurse anesthetists? Why are we taking out certified registered nurse anesthetists?

MR. PETTENGILL: Because they're paid under Part B.

DR. WILENSKY: Any comment about the recommendation?

All in favor?

All voting no?

All not voting?

All right, the next recommendation?

DR. LOOP: I was just pointing out to my learned colleague here that the CRNA cost and the CRNA reimbursement for education are not the same, reimbursement for training. So I don't know whether that's true across the country, but they ought to take a portion of that that is reimbursed and delete that rather than taking away all CRNAs.

DR. ROWE: For his institution, the cost, he gets Part B for it.

MR. ASHBY: But remember, the only thing that is at issue here is not the payment but their salaries as a mechanism for measuring prevailing labor conditions in the area.

DR. LOOP: I thought it was just for Part B reimbursement.

MR. ASHBY: They are paid under Part B, but what we pay them isn't the issue here. It's their salary rates when they are employed by the hospital that's the issue here. HCFA's thinking was, if they're not going to be paid under the Part A system then why have their salaries helping to calculate the average wage rate for the area.

DR. WILENSKY: This was not in terms of their reimbursement. This was only in terms of whether to count that salary as part of the wage rate adjustment. We'll have the vote amended.

The next one, Joe had requested that we delete the nearly always phrase in front of purchased at the end, and also to have the Secretary should reexamine as opposed to carefully reexamine.

MR. SMITH: Joe's changes go to part of my concern. I think this one, Gail, fails your test of decent Medicare payment policy and falls into, how do we shove more money in one direction. Joe had raised the question earlier of an inappropriate geopolitical tilt in some of the recommendations. I think this one has that.

I like the first option at the beginning of Jack's slide which was, do nothing. I would prefer -- we don't have much evidence here that costs are misclassified. This is redistributive in a way that we don't fully understand, and it doesn't have much to do, based on anything that we know, with good Medicare payment policy. Now maybe a careful reexamination would help get us there, but the wording of this is suggestive of an outcome that I don't think what we know justifies.

DR. WILENSKY: I appreciate the concern you're raising. As I read this recommendation, I don't see that it says that, so it would be very important what would be in the text. But as I read this recommendation now it says, the Secretary should reexamine the cost in the labor share to ensure that each labor share only includes cost for resources that are purchased in local markets. I don't see anything wrong with that statement.

DR. ROWE: Yes, but, Gail, the discussion that we had about this revolved around a model that was present of an estimate of what kind of change would occur, so that's

what we're basing our responses on. It's not like we didn't have the discussion. And when we asked how much the redistribution was it was said, we don't really know, it's buried in the data somewhere. Until we know that I sort of feel as David feels.

MR. SMITH: I think the problem here is there's no reason to ask the Secretary to reexamine unless we think there's a problem that ought to be fixed, and the discussion in the text suggests that the problem is a problem which could be fixed by redistributing from urban to rural. I don't think that case is made, and unless it's made I'm not sure why we would ask the Secretary to reexamine something.

Then the example we have, which further buttresses the presumption that this index is wrong is an example that would result in a 4 percent shift, or a 4 percent reweighting, which would result in an unknown shift having unknown consequences. I just don't think we're there.

MR. HACKBARTH: I would not support going to 67 percent because it's in the middle. I do think that there are a number of anecdotes or reasons why you might suspect

that the current allocation is not the right one, because as Craig said, it's an absolute test now. If there's any labor involved it's considered to be local. We can all name a half-dozen examples off the top of our head what that assumption would not be an accurate one.

So I'm not sure what the outcome would be, and we're not suggesting that the Secretary just implement something. We're saying, we need more information to evaluate whether this is in fact a problem or not. If we don't get more information then we're going to be in a position where a policy judgment is made without any data.

DR. ROWE: We can get more information without the Secretary getting more information.

DR. WILENSKY: We do those kinds of recommendations, ask the Secretary to look at something because we think there's an issue. We did that when talking about our disproportionate share discussions last time in terms of the distributions.

I think that we're going to have to go back -- if we adopt this, we have to go back and make sure that the

text supports the discussion, which is that currently the presumption is any labor is local labor. Now that is an extreme assumption, and the question of trying to assess empirically under what conditions these kinds of issues become relevant and how to try to deal with them strikes me as appropriate.

So I think that the text discussion needs to follow the sense of what was raised. But I guess I don't see that what we're asking the Secretary to do in the text is inappropriate.

DR. ROWE: I don't see that either from that point of view, Gail. I guess to reiterate my earlier point, I don't want to be cast in taking a position that all labor is national or all labor is local, and there are many distinctions and examples that we could give here that we all have. I mean, that's silly.

DR. WILENSKY: But that is where we are now.

DR. ROWE: I understand that. I'm thinking about why are we doing this at all? You've heard what I have to say about overall margins and Medicare margins, et cetera,

and if that's what we're trying to fix my view is there isn't a problem there.

MR. ASHBY: No, we originally got into it because we really thought that there was a good chance that the shares were inappropriately defined now when you really think about how these markets work. On both the labor side and on the profit it seemed --

DR. ROWE: You can't give us any estimate of what the redistributive effect would be?

DR. WILENSKY: He's not at this point not even saying what the error is.

DR. ROWE: No, but we did have presentation for half an hour of a model. What would be the effect of that model? We don't know. How can you ask us to vote if we don't have --

DR. WILENSKY: Because we're not asking to recommend 67 percent. We're asking to go back and look --

DR. REISCHAUER: What we're asking is, do it better than it's done now. We know it's wrong. The better might be a very marginal change after the Secretary looks at

it, or it might be 67 percent even, but I doubt it. I think it's probably going to be a very, very small change.

DR. WILENSKY: But we know what we have now is wrong.

DR. WAKEFIELD: I think wage index in total is a very serious issue, not just for providers in rural areas to try to get a handle on what's going on with it, but it is also for policymakers. It is a big, substantive topic of discussion. The more light we can shed on what the component parts are that may or may not be problematic, I think we do a service to both policymakers and to providers. Some of the researchers that I talk to say that this is probably one of the areas that is really off, but all we're doing is talking in anecdote until we've got good data.

In part what I hear, and I guess it's just me now and the hour, but it's somehow saying we shouldn't look at this, even though we're going to be informed if the Secretary is looked at it. For some reason the Secretary shouldn't examine it, when we're quite certain that there are problems, but we don't have good information about the

magnitude of those problems. So I'm having a tough time with the difficulty of this, I guess I'll say, and I'll just get to the point which is, I support the recommendation minus the word carefully.

DR. STOWERS: I'm going to be redundant on purpose, and that is to say that we know we've got a problem here. Mary, I agree, we need to take a look at it. I agree with not setting the 67 percent. But to those in the rural areas, obviously this needs to be looked at and we need to do it.

DR. WILENSKY: Julian, do you want to say something?

MR. PETTENGILL: I want to just point out two things. First, the 67 percent was nothing but an illustration. It was only a means of giving you a sense of scale.

MS. RAPHAEL: But how did you come to that, Julian, because it wasn't clear in the text?

MR. PETTENGILL: I came to that by recognizing that the proportion of labor costs that is attributed to

wages and salaries is 63 percent. The remainder from 63 percent to 71.1 is these categories whose origin, whose relevant classification is uncertain. We split the difference, taking 67 percent just to give people a sense of the scale of what changes in the labor share might produce. Not to indicate what we thought would really happen if HCFA reexamined the weights.

The second point is that HCFA reexamines the weights every time they rebase the marketbasket, which they do periodically. It was due this past year. They deferred it because they had a new Administration coming in and didn't have somebody at the top of HCFA to make decisions. So presumably they will be doing rebasing the marketbasket quite soon.

When PPS was first implemented, the labor share was 74.1 percent; not 71.1 percent. It has changed twice as a result of rebasing the marketbasket weights. This is not something that is extraordinary. It's happened before. And it's not out of bounds to think that the assignment of the components wouldn't change again with reconsideration.

That's all. The recommendation is, take a look.

DR. ROWE: If what you're saying is they take a look automatically...

MR. ASHBY: Yet their assumption all the way along for the whole 15 years has been all labor is local. It still has driven their thinking all the way along.

MS. RAPHAEL: Maybe that's right.

DR. WILENSKY: That is why it's two different things. They will do a reassessment. But we're saying also, reconsider the assumption that you've made that all labor, by definition, is local. Have this be empirical, not an assumption.

MR. SMITH: Gail, just to make sure I understand the assertion that that's the assumption. As I look at Table W-7 which deconstructs the labor shares, it seems to me that some of what's listed as national has clearly got a labor component in it. Non-medical professional fees, that's not laborless. Neither is business services.

So maybe I'm misunderstanding something, but if you go to the table in the back that deconstructs the index

what you find is that the assertion that everything that's got labor in it is local simply isn't true.

MR. ASHBY: Are you sure you're looking at HCFA's assessment or our assessment?

MR. SMITH: I may have misunderstood the footnote and the reference to the table, Jack.

MR. ASHBY: The national one was us suggesting that this might be something less than all local. By the same token, we weren't going to say it's all national either.

MR. SMITH: I'm sorry, I misunderstood your reference.

DR. WILENSKY: Again, I want to reiterate that what we're suggesting here is that just as HCFA reexamines empirically the share, that HCFA reexamine the assumption that is made. I'm a little surprised at the vehemence, and I'm thinking this is vehemence without empirical basis, because we don't know what the number is.

MR. SMITH: I think it would be my concern, Gail, and I appreciate the concern about our anxiety. I think

context matters a lot here. In the context of two months of discussion about rural-urban disparities and a whole day spent on a series of efforts to move money into rural areas, which I have no quarrel with, we have a recommendation which is redistributive and large and unsized and unargued.

Now I don't want to argue against good information and more data. I think the context in which we're asked to vote on this suggests that we're for a recalculation that would result in a redistribution between urban and rural. I don't think we're prepared to do that.

DR. ROWE: I'd like to say, since I've just been accused of working in a data-free environment I'd like to respond to you, Gail. I think I'm where David is. I mean, how can we say we're against better analysis? That's not what we're trying to say.

What we don't want to say is that MedPAC supports changing to a new distribution here based on a new analysis irrespective of the implications of redistributing an unknown amount of dollars from an unknown set of hospitals to another unknown set of hospitals, right, David? If we

can be clear about that, fine. But my concern is that --

DR. WILENSKY: Where is it that you're -- I agree, I would certainly not support such a recommendation. Where is --

MR. SMITH: But the recommendation doesn't exist on the moon, Gail. The recommendation exists in the context of this chapter and this discussion. Perhaps if we wanted to rewrite it to say questions have been raised and maybe we ought to hire a contractor to look at --

DR. WILENSKY: What we're requesting is that HHS, in its multibillion dollar activities, needs to look at this issue. That we think that the assumption that all labor is local, which has thus far been a part of this calculation, isn't appropriate and that it ought to be part of the empirical analysis.

MR. HACKBARTH: I assume the text will say something like Julian just reported, that this is a normal thing.

DR. WILENSKY: Part of it is normal. The reexamination of the amount for labor is normal.

MR. HACKBARTH: And it hasn't happened -- it's a point of concern or contention and we recommend that the Secretary take a look at this and give us some more data.

MR. SMITH: If it's normal, why do we need to make a recommendation?

DR. REISCHAUER: If I'm not wrong, these are national weights, and the Secretary is going to go in and see how much is purchased locally and how much is purchased nationally, and the ending weights are going to be dominated by the urban areas, which in fact are the national weights right now. I don't think there's going to be a huge change when you finish all this.

I think it's going to be a lot of work. And I think probably what we should be saying is something like, the Secretary should do an analysis of this problem to see -- first of all, to see whether this is going to end up being a significant thing at all. My guess is it's not going to be, just because the urban areas, their prices are close to the national averages and they're determining these weights anyway.

DR. WILENSKY: I think it well could be in some ways too bad, although it's not an inappropriate assumption, that the splitting for illustrative purposes, that that decision was made rather than 10 percent off of where they are for just the reasons that you have suggested. But what I see us recommending is that when the normal course of reexamining the labor share occurs, that this assumption -- that some empirical work be done to test this assumption about local versus national weights.

While I think that's appropriate and consistent with the kinds of recommendations we make to improve payment all the time, I think it's particularly important to deal with this right now for political reasons -- political reasons to try to get better policy, not political reasons in terms of just bowing with the wind -- in the sense that this issue is of great concern to the rural areas. What we're suggesting is that it ought to be informed with some empirical analysis as opposed to having arguments based on gut beliefs that aren't informed with empirical analysis.

We've heard this notion of, is it mostly in a

national market, is it mostly in a local market? Rather than rely on anecdote, what we're saying is that we ought to have some empirical analysis and shed some light on this.

MR. ASHBY: It's only fair to point out that we do have some rural groups running around arguing how extremely low their labor shares are and how the system discriminates against them and so forth. That's all sort of dataless as well. We tend not to just believe that at face value any more than the rest, but there is certainly a lot of opinion in that direction.

MR. HACKBARTH: I assume that the text of the report will not include the modeling of the 67 percent, because that was just grabbed out of the air. I'd second what Gail said. I think if we don't address things like this with better information, then we run the risk that Congress, faced with the anecdotes says, we'll impose 67 percent just as a compromise between 63 and 71, and I think that's bad policy.

It's something that should happen in the normal course of events and it hasn't. I think it's entirely

appropriate for us to say, we need to get on with this or something uninformed by data could happen.

DR. WILENSKY: I do think that this portion of the discussion -- we need to go ahead to see where the commissioners stand on this issue. But it certainly needs to be reworded in terms of the discussion so that you can reflect the kinds of issues that have been raised here.

All right, the recommendation to delete carefully, to delete nearly always, is how the wording stands now. Are there any other changes people want to propose?

All voting in favor?

All voting no?

All not voting?

Then are you comfortable that you have enough guidance on what goes into the recommendation?

MR. ASHBY: Yes.

DR. ROWE: Now that we've voted, I think that David and I had not discussed this issue previously [inaudible] It can't be that the two of us were both completely whacko. There was a sense that in some of the

discussion or the modeling or the example that was given or something that this was something that MedPAC knew that this was redistribution, we knew how much money it would be, and this is our model, this is our proposal. There was a sense -- now maybe we were the only two people that got that.

DR. WILENSKY: It was unfortunate that because an illustration was chosen that involved a large number, although as Bob just suggested that when you think about what the weights are going to be, the fact is they're going to be dominated by what goes on in the urban area because that's where the weight is. And unless you think that somehow when you try to calculate national versus local that really is going to skew that a large amount, which is very unlikely -- I mean, it's probably instead of 71 it might be 70 or 69.5.

DR. ROSS: Let me add a coda to that too, because as David pointed out, the flavor of the discussion or the simulation is how can we shovel money from one group to another? Remember the criteria that Jack laid out at last month's presentation -- Jack Ashby -- of the options that

we're bringing to you include things that staff would recommend as well as a number of options that are out there on the table because they are being discussed on the Hill. We simulated them so you could see what they do, and didn't necessarily make a recommendation.

So a number of those options that look like they're just taking money from Peter to Paul, those are being discussed. That may have colored some of the discussion when in fact that wasn't the intent of this particular policy.

DR. WILENSKY: It was, as much as anything, to give you some rationales to why we were concerned about this when our focus has been how to try to get the best Medicare payment that we can, and then if we think there are other problems that need to be addressed, decide how we want to address them.

The option for the base payment rates of rural and other urban areas.

My recommendation is that no more paper come to the commissioners without having page numbers on it so when

we want to refer we can know how to refer.

It's right on the page after the draft recommendation we just discussed.

MR. ASHBY: Again, we didn't put this in a draft recommendation. It wasn't to that extent yet.

DR. WILENSKY: I understand. At the moment it seems like I would be with number one. My sense is that we're not doing anything now. That we believe that we are doing recommendations at this point in time that will improve the Medicare payment, and that at least with regard to these other two we're not in a position where we're interested in making these other recommendations.

MR. HACKBARTH: I agree that this isn't the time to do something on this. I was curious though as to number two and why this was explicitly linked to the expanded transfer option. How are they connected?

MR. ASHBY: As we said they're parallel in the sense that both would raise the rural base payment rate, and how they differ is in how it ends up being paid for. So that raises another option for --

DR. WILENSKY: But we can take that up next time.

MR. ASHBY: But we can take that up next time, which was kind of the point there.

DR. WILENSKY: The draft rural referral. I'd like to ask that people think about this as one of two options for this recommendation. One is we can require meeting the same wage threshold, or the one that was in the text as an alternative which is that they wages should be at least above average in the state, which strikes me as a somewhat less harsh rule.

MR. KERNS: In the state rural area, if they are a rural hospital.

DR. WILENSKY: In the state rural area, yes. I think I would be more comfortable in making -- at the very least they ought to be above average in order to get this special treatment.

MR. HACKBARTH: How many rural referral centers would lose their status based on using the state average?

MR. KERNS: Twenty-three percent of those reclassified, 23 percent of 177; 40, something like that.

MR. HACKBARTH: And then if it's 106 percent how many would lose?

MR. KERNS: About half, so 85.

DR. WILENSKY:

I feel comfortable saying, if you're not at the average, forget it. That's it. But putting to the same one just strikes me as a higher threshold than we're going to actually get, whereas maybe we can sell this.

MR. KERNS: One small thing to point out is the criteria for reclassification was just reduced from 108 to 106 and they're not even meeting that one.

DR. WILENSKY: Whatever. Let's get them to above average. I don't really disagree in principle. I'd just like to make sure -- because I think we're more likely to stay where we are if we have this --

DR. ROWE: Is above average above the average or above the median?

DR. WILENSKY: I was thinking of it as 100 percent which would make it above the average.

MR. KERNS: What was your question, Jack?

DR. WILENSKY: Was it above the average or above the median? Probably the median is lower.

MR. KERNS: Average, the mean.

DR. WILENSKY: The mean would be higher, I assume. The average should be higher, and it would be in the way up to -- I would like 106 percent. I don't think that's an unreasonable target. That's the wage rate that's now in law. I would like to, at the very minimum, to not have wages that are at the average, and to be able to claim special status strikes me as inappropriate.

DR. ROWE: And the mean would be higher than the median.

DR. WILENSKY: The mean will be higher -- I'm saying that. I assume that --

MR. KERNS: Assume larger hospitals pay more, and it's a reasonable assumption.

DR. WILENSKY: I don't know it, but my guess will be the mean is above the median. So I would prefer to see the recommendation say at least should be the average, require the average for reclassification.

MR. KERNS: The second measure, the compromise measure.

DR. WILENSKY: Right.

MR. ASHBY: So we'll change the wording accordingly and that's what you're going to vote on?

DR. WILENSKY: Why don't we vote on that first, and if you want we can vote on this one second?

All those in favor of requiring that they meet at least the average wage threshold requirement, voting aye?

Voting no?

Not voting?

Is there an interest in having a vote on this higher threshold?

Okay, we'll leave it at this. I actually initially supported the recommendation, this one we're talking about, the sole community hospital. Initially when I read what was in there I supported the notion that was in there of counting the critical access hospital in determining for sole community hospital purposes whether there was another hospital in the area.

But as I have thought about it more, I don't find that consistent. That is, when you're a sole community hospital presumably you are acting in a particular position in your community; that you're the only full-service hospital in the area. I think that's a relevant requirement, that you be the only full-service hospital in the area.

While I understand the concern that you've raised or that HCFA has raised that with a substantial increase in the number of critical access hospitals popping up, do we now lose the sense of what it means to be a sole community hospital. My comment would be, if that's really a problem we ought to reexamine our definition of a critical access hospital and not reexamine how we define sole community. Sole community is the only full-service hospital in 35 miles, or however we define it. I think that's the right distinction.

If we're somehow getting non-critical access hospitals into the critical access definition then that's what we ought to go back and reexamine. That's just as I

have thought about it more, this isn't the right place to clamp down. It's what we may be allowing in as critical access hospitals.

MR. ASHBY: As we said before, that's probably an issue we want to monitor is the escalation of what CAH means. Hopefully, the low volume adjustment would make some progress in that regard, because if someone's under the margin that would be helped by this then we may be able --

DR. WILENSKY: Maybe they don't have to become critical access hospitals.

MR. ASHBY: Exactly, we'll have less becoming critical access.

DR. WILENSKY: Right. And I think that would be a better way to fix this problem.

DR. ROWE: If you think about it from the point of view of the beneficiaries rather than the hospitals, how would this recommendation help the beneficiaries? It wouldn't.

MR. KERNS: It would help the trust fund.

DR. ROWE: I mean, it's all about hospitals. It's

not about beneficiaries. It's really not going to help -- the hospitals are what they are. Changing the label isn't going to --

MR. KERNS: It would change the way they're paid.

DR. WILENSKY: But it's about what it does to hospitals. The fact is, from a beneficiary's point of view you are still only assured that there will be a full-service hospital within 35 miles.

DR. ROWE: That's my point.

DR. WILENSKY: That's why I recommend we do not adopt this.

DR. BRAUN: It almost seems as if it ought to be upside down. Critical access hospitals should not be able to become one if they're right close to a sole community hospital.

MR. ASHBY: That is also policy, Bea, they have the same 35-mile standard except that the states can waive the standard.

DR. WILENSKY: Let me go back and say that if we think there's a problem, I believe the problem may be how

the critical access hospital is being defined. If at some point we want to say that, let's go back and have that for consideration. Obviously we're not ready to say that today.

DR. ROWE: So we'll get rid of this recommendation.

DR. WILENSKY: We'll get rid of this recommendation, and I'm open for reconsideration at the next appropriate time on definitions of critical access hospitals if we think that's a problem.

MR. KERNS: We did talk about it last month, the same issue, with the rapid increase in critical access and whether --

DR. WILENSKY: You told us that but you haven't -- and I gather it's because governors can ignore --

MR. ASHBY: Yes. Now that we have our road mile figures we can tell you that only 20 percent of the CAHs are actually more than 35 miles from another hospital.

DR. WILENSKY: But what are they? It's one thing to say that they're not more than 35 miles. Are these usually like 20 miles? Are we talking about 15 --

MR. KERNS: They're supposed to be 35, but it can be waived.

DR. WAKEFIELD: But we don't know how many it's been waived --

DR. WILENSKY: How many are being waived and what impact is it? We've raised the issue --

MR. KERNS: I would be happy to look into that.

DR. WILENSKY: That's what I'm saying, I think that the issue about whether there is inappropriate designation of the status of critical access hospitals is an issue that we ought to be willing to make a decision. While the issue was raised in our March meeting, informing us about what the real implications are -- again, it's one thing to say they're not meeting the 35-mile, but are we talking about 29.5 miles or 31 miles?

MR. ASHBY: We do have some data on that. Now most of them fall between 20 and the 35. Almost all of them are in that --

DR. WILENSKY: So we're not talking about big clusters of holding centers near sole community hospitals.

MR. ASHBY: No.

DR. WILENSKY: Again, if you want to come back in our next discussion and say, here's now an informed, empirical analysis of what's been going, and we'll also have another year --

MR. ASHBY: Sure, and then we can monitor the progress on the program itself too.

DR. WILENSKY: Exactly. So I think that it may be that we will --

MR. ASHBY: We'll keep it on the agenda.

DR. WILENSKY: -- have something to say about how critical access hospitals are being defined, and what the empirical implications are of what's gone on, but not do it this way.

DR. WAKEFIELD: I do want to make one comment though on CAHs, and that is the way we've got them described in the narrative -- and I'll be happy to provide you with at least my suggestion related to language -- is not exactly on target. It's not quite the characterization that I think is consistent with what's in statute. That is we've got them

sounding almost like MASH units, and in fact they're not, or they don't have to be. They never, to my knowledge, were designated to be something that focused purely on ER and enough inpatient services to stabilize. That's not exactly what you're saying but it could be interpreted that way.

In fact they're limited in terms of inpatient capacity, bed size, and length of stay averages. But there's no statutory language that says, CAHs can only offer this particular service set, for example. So I want to at some point go back, not now, but with the staff and make sure that we've got the accurate characterization consistent with what's in statute and what I think was the intent, which to me this leads you down a slightly different road.

I'd also say in terms of the governors' designations, I think we really do need to know what numbers we're talking about there because otherwise this could be a very small issue or it could be a very significant one. It keeps coming back without data.

DR. BRAUN: I do think we want to know how often do we have two hospitals in one town and one of them would

have to close except now they've found the CAH designation and they can stay open. I don't think we want that to happen.

DR. WILENSKY: That's why it really does strike me that the questions we're raising are legitimate questions that have to do with the status of critical access hospitals and we ought to have some analysis done, and we can make recommendations that we think are appropriate when we have that analysis.

DR. WAKEFIELD: Should we vote on this?

DR. WILENSKY: My sense was that I saw the heads nod so I'm inclined to --

DR. WAKEFIELD: I wasn't asking for one.

DR. WILENSKY:

Do we have one more recommendation on this?

MR. ASHBY: No, that's it for the recommendations on PPS hospitals, but we now have psych facilities.

DR. KAPLAN: Last month we talked about the reason for studying PPS-exempt psychiatric facilities. The BBA established a target cap for these facilities based on the

75th percentile of all facilities targets. For each discharge, psychiatric facilities are paid at the lower of their own costs, their own target, or the target cap. The aggregate margin decreased 5 percent to minus 2.3 percent in the first year the cap was in effect. Beneficiary access may be negatively affected by the target cap.

One target cap treats all psychiatric facilities as if they have similar case mix and treatment patterns. However, we found that government-owned hospitals are different. They admit a higher proportion of disabled beneficiaries compared to aged, and a much higher proportion of patients committed involuntarily. Their length of stay is about double that of either other freestanding hospitals or hospital-based units, and more than half of the government-owned hospitals have a cost per case over the target cap in both urban and rural areas.

Rural hospital-based units don't look very different from other freestanding or urban units, but 30 percent of them have cost per case over the target cap. We'll look a little closer at rural units in a moment.

First, on this slide we see average cost per case by hospital type, and the average for facilities with cost per case over the cap. In each group, facilities with cost per case over the cap are way over. As you can see, government hospitals have a much higher average cost per case, and hospitals over the cap have a cost per case about twice the size of the cap. This figure also shows that in each group rural facilities have higher cost per case than their urban counterparts.

As I said before, 30 percent of rural hospital-based units have cost per case greater than the cap. When we examined the units more closely using the UICs, we see that except for areas non-adjacent to metro with a city of 10,000 or more, as facilities become more rural the average cost per case increases.

However, length of stay doesn't increase in the same way as cost per case. For example, in the two areas with the seven, 11-day average length of stay, the average costs are 30 percent higher in the more rural area.

We were unable to use the same weights to derive a

case-mix index for government hospitals because they are so different. However, preliminary case-mix indices for the other two facility types show that rural facilities have a higher case mix than urban facilities of the same type. Urban other freestanding hospitals have a higher case mix than your urban units, but the case mix is the same for rural other freestanding hospitals and units. This information was not included in your mailing materials because I didn't have case-mix indices then.

One target cap for all facilities does not appear to work well for psychiatric facilities. The evidence shows substantial differences in these facilities although we may not know exactly why all the differences exist. The prospective payment system for inpatient psychiatric case is mandated to begin on October 1st, 2002. Not everyone thinks that the PPS will happen on time, so one could think if the recommendation on the screen as the fallback just in case it doesn't.

There also was some discussion in the mailing of rural hospitals closing psychiatric units to apply for

Thank you.

DR. KAPLAN: Thank you.

DR. WILENSKY: Thank you, that was a good and appropriately detailed discussion on the inpatient hospital. ***[Next agenda item begins]*** Home health care, Sharon and Sally?

I apologize if there are people who are waiting for public comment, but we're going to go through the end of this since we're already about 45 minutes behind.

MS. BEE: In this session this afternoon we will conclude a discussion that we began last month on whether or not rural home health should be exempt from the home health prospective payment system. Last month we discussed the components of the new PPS, information from the previous cost-based payment system, and additional data needs. Today I'll quickly review our analysis and present two recommendations for your consideration.

The concept behind all of our findings is not whether or not the PPS is doing well, but whether or not it will work differently in rural areas. Our first finding is that the payment unit and eligibility for multiple episodes